



Greensboro Health Care
Credit Union

A fee of \$ _____ will be charged to your account

Stop Payment Form – ACH / Electronic Check

Members First and Last Name

Today's Date

Account Number

Phone Number

Company Name

Check Number

Amount

Written Request Renewal Verbal Request

Account Type: Checking Savings

Request Type: Stop Single Entry Stop Multiple Entries Stop All Future Debits Under a Specific Authorization*

*If this stop payment order instructs the credit union to stop all future payments pursuant to a specific authorization involving a specific Originating Company, account holder should initial here to indicate that they have contacted the Company to revoke the authorization. Account holder agrees to provide a copy of the revocation of authorization to the credit union upon request. _____ (initials)

STOP PAYMENT TERMS AND CONDITIONS

By directing the credit union to stop payment on the above transaction(s), the account holder agrees that the credit union is not obligated to honor a stop payment request that does not contain accurate information provided in a timely manner. The account holder understands that it is necessary to provide the correct information related to the transaction, and that a failure to do so may result in the payment of the above item. The account holder agrees to hold harmless and indemnify the credit union for all expenses, costs, and damages incurred by payment of the above item if such payment is the result of failure of the account holder to furnish any item of information requested above completely, accurately, and correctly, according to the time requirements noted below. Verbal stop payment order will cease to be binding after 14 calendar days unless written confirmation is provided to the credit union by the account holder within that 14 day period.

Stop Payments of ACH/Electronic Check Items Affecting Consumer Accounts

This stop payment order shall remain in effect until the earlier of (1) the withdrawal of the stop payment order by the account holder, or (2) the return of the debit entry, or, where a stop payment order is applied to more than one debit entry under a specific authorization involving a specific Originating Company, the return of all such debit entries. For PPD entries, IAT entries, and recurring WEB entries: Three banking days advance notice prior to the expected transfer date of the debit entry is required to implement the stop payment request. If the stop payment order is received within three banking days of the expected transfer date, the credit union will attempt to satisfy the request of the account holder, but will not be held liable if sufficient time was not provided. For ARC entries, TEL entries, Single Entry WEB entries, RCK entries, POP entries, and BOC entries: The stop payment request must be provided to the credit union in such a time and in such a manner as to allow the credit union reasonable time to act on the request prior to acting on the debit entry.

Stop Payments of ACH/Electronic Check Items Affecting Consumer Accounts

The stop payment order is effective for six months unless it is renewed in writing. The stop payment order must be provided to the Financial Institution at such time and in such manner as to allow the credit union a reasonable opportunity to act upon the stop payment order prior to acting on the debit entry.

X _____
Member's Signature

Please review the information above for accuracy, then sign. You may fax the signed form to (336) 832-8129, mail it to Greensboro Health Care Credit Union 1200 North Elm Street, Greensboro, NC 27401, or stop by any branch location. The credit union must have this form hand delivered, mailed or faxed before your request can be processed. If this request is sent by fax, it is your responsibility to contact the credit union to verify the request was received and processed.