# ACH Stop Payment Request

Member Name _____ Member # _____ Suffix _____

Daytime Phone # _____ E-Mail Address _____

Payment Date: _____

Amount: _____

Payable to: _____

☐ Stop all future payments

☐ Stop this payment: From: _____ To: _____

☐ **I agree that my account will be assessed a fee of $20 for this service; funds must be available at time of request.**

By submitting this form I request the Credit Union to stop payment on the electronic funds transfer shown above. I agree to hold the Credit Union harmless from any and all claims, damages, loss, liability or expense arising from the Credit Union acting on this request. I also understand and agree that if this request is not submitted to the Credit Union **at least three business days before the scheduled payment date**, the Credit Union will have no liability to me if the payment is made notwithstanding this request. Any effort by the Credit Union to act upon a stop payment request submitted fewer than three business days before the scheduled payment date is made as an accommodation only and is not guaranteed. Further, the Credit Union will have no liability to me for failing to stop my payment if I do not provide complete and accurate information on this request, even if I submit the request in a timely manner.

This stop payment will remain in effect until the withdrawal of the stop payment order in writing by the member, or the return of the debit entry, or when the stop payment applies to more than one debit entry, until the return of all such debit entries, whichever occurs earliest.

_____ _____

Authorized signature Date

To submit, please fax or mail completed and signed form along with any requested support documentation to: **NIHFCU Fax: 301-770-5372** Mail: **P.O. Box 6475 Rockville, MD 20849-6475**. You may also drop this form off at any NIHFCU branch location.

**CREDIT UNION USE ONLY**

System updated and Fee taken by: _____ Date: _____