Kaleida Health Federal Credit Union

100 HIGH ST D1-588 Buffalo, NY 14203 Phone 716-859-5960 Fax 716-859-5963

STOP PAYMENT REQUEST

Date: ______________________________

Acct # and Checking #: ____

Name: ____

Address: ____

____

Check #: __________________ OR item is ACH (*please check)* __________________

Dollar Amount: ______________________________

Date on Check or Date ACH was Authorized: ____

Payable To: ____

This stop payment request is binding upon the institution only if it accurately states the exact information requested above, and it is received by the Credit Union in sufficient time to give the Credit Union a reasonable opportunity to act upon it. If the request has been made within such time, and with such specificity, it will be effective for six (6) months from the day it is received, unless it is renewed in writing. I agree to pay the Credit Union the stop payment request fee of **$25.00** and to indemnify and hold the Credit Union harmless from all expenses and costs which it incurs due to its compliance with this request. The stop payment order will remain in effect until the earlier of (1) the withdrawal of the stop payment order by the receiver, or (2) the return of the debit entry.

Member's Signature: ____ Date: ________________

CREDIT UNION USE ONLY:

Request Ordered By: ______________________________

Company ID# ______________________________

ODFI # ______________________________