



1800 W. MARKET STREET • POTTSVILLE, PA 17901-2002 • (570) 628-2400
www.caclfcu.org

STOP PAYMENT AUTHORIZATION

I hereby request the CACL Federal Credit Union to stop payment on the share draft(s) described below unless already paid, certified, or accepted. I understand that this request will cease to be effective six months from the date shown below unless it is previously canceled or renewed in writing by me. The credit union will not be liable for payment of the draft(s) contrary to this request unless payment is caused by the credit union's negligence and causes actual loss to me. The credit union's liability shall not, in any event, exceed the amount of the draft(s). I agree to reimburse the credit union for any loss it sustains in honoring this request.

Member Name: _____

Account Number: _____

Draft Number or Range: _____

Amount of Draft: _____

Stop Payment Fee \$20.00 from Share _____

___ Telephone Request - Date: _____ Time: _____

___ Office Request - Date: _____ Time: _____

Employee Signature: _____

Member Signature: _____

Note: A stop payment order which was made via telephone will lapse within (14) calendar days unless confirmed by signing and returning this form to the credit union.

Credit Union Use

Verified by: _____

Date Verified: _____

