PO Box 100167, Columbia, SC 29202
office: 803-978-2101 fax: 803-704-1008
email: curis-info@curisfinancial.org
www.curisfinancial.org

STOP PAYMENT REQUEST

Stop Payment Order

Account Number:	Check Number:	Check Amount:
Date of Check:	Replacement Check Issued: ☐ Yes ☐ No	Replace Check Number:
Date of Stop Payment Request:	Time of Request: ☐ AM ☐ PM	Method of Request: ☐ In Person ☐ By Mail ☐ Phone

MEMBER AUTHORIZATION

Please stop payment on the check listed above. This stop payment order will be effective for six (6) months from the "Date of Stop Payment Request." The undersigned agrees to hold the Credit Union harmless for said amount and for all expenses and costs incurred by it on account of refusing payment of said check, and further agrees not to hold the Credit Union liable on account of payment contrary to this request, if same occur through inadvertence or accident, or if by reason of such payment other items drawn by the undersigned are returned insufficient. Further, the undersigned reaffirms the terms and conditions set forth in the Membership Account Agreement, incorporated herein by reference.

NOTE: This Stop Payment Order applies to any actions to submit the item specifically described in the paper form. The Credit Union is not able to control the actions of third persons; and therefore, is not responsible or liable for any actions undertaken by any person that results in an alteration of the Check described herein, or any action to convert the item to an ACH or other electronic item that is then submitted for payment.

Signature	Date	Signature	Date

STOP PAYMENT REQUEST CANCELLATION

The Stop Payment is hereby Canceled.

Signature	Date	Signature	Date

FOR CREDIT UNION USE ONLY

Employee Name:	Request Type: ☐ Written ☐ Oral
Comments:	