



For Branch Use Only	
Employee Name:	_____
Date Form Received:	_____
Time Received:	_____

## CHECK(S) STOP PAYMENT REQUEST

### Instructions

Complete this interactive form, print, sign, and return to Icon for your request to be processed. Your signature is required on this stop payment form. We must receive this completed form in our office for this stop payment to be placed. A facsimile copy is acceptable and can be faxed to us at (208) 343-4587. The applicable stop payment fee will be charged to your checking account listed below and must be collected prior to the stop being placed.

### Member Information

Date: \_\_\_\_\_ Member Number: \_\_\_\_\_

Member Name: \_\_\_\_\_

Icon's computer system requires the exact check number and amount to identify the check to be stopped, unless the item(s) is stolen, in which case we need the specific check number(s).

Please stop payment on item number \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ dated \_\_\_\_\_ in favor of \_\_\_\_\_ . A duplicate has not  has been  issued.

Check # : \_\_\_\_\_

In requesting you to stop payment on this item, I agree to hold you harmless for all expenses and costs incurred by you on account of refusing payment thereof, and further agree not to hold you liable on account of payment contrary to this request if same occurs through inadvertence or accident, or if by reason of such payment, other items drawn by the undersigned are returned because of insufficient funds. I understand that if the item described herein is presented for payment at any Icon office (other than the office of account) on the **same business day** this stop payment request is made, you will not be liable for failure to honor the stop payment request. If the item is guaranteed by Check Protection, this request becomes void.

**This request is effective for only 6 months. If a longer time period is needed, a renewal will need to be made.** I understand this request may be withdrawn by me at any time. No renewal or withdrawal hereof shall be valid unless in writing and served at the Credit Union. I understand I will be responsible for the amount of the item if it is negotiated after the request has been withdrawn or after it has expired without being renewed.

Reason(s) for requesting payment stopped: \_\_\_\_\_

You are hereby authorized to charge my checking account with an initial Stop Payment fee of:

\$25.00 (for 1 check)  \$50.00 (for 2 or more checks)

Daytime Phone Number: \_\_\_\_\_ Member Signature: \_\_\_\_\_

*The above request is withdrawn:*

Release Authorization: \_\_\_\_\_ Date released: \_\_\_\_\_

Date item stopped and released by Credit Union: \_\_\_\_\_

**Return to your nearest branch | Fax: (208) 343-4587 | Email: info@iconcreditunion.org**