



ACH Stop Payment Form

Date of Request _____

Member Name _____

Member Number _____ Checking Savings

Daytime Telephone Number _____

Type of Stop Payment

One Time Stop Payment

Permanent Stop Payment

Any Amount

Amount of \$ _____

Reminder:
ACH Stop Payment Order is not to be completed for transactions performed with a debit or credit card.

Merchant/Company Name _____
(Merchant name must match exactly as it appears on your statement.)

Please stop payment on the electronic debit described above unless you have already paid or accepted it. I understand this ACH Stop Payment Request will remain indefinitely unless it is subsequently canceled in writing by me and the Stop Payment Request must be received by AFFCU at least *(3) three business days* before the scheduled date of the transaction in order to be effective. AFFCU may accept a Stop Payment Request after that time but will not bear any liability if it does not act on the order. AFFCU will not be liable for payment of an electronic debit contrary to this request unless payment is caused by the AFFCU's negligence and causes actual loss to me. AFFCU's liability shall not, in any event, exceed the amount of the electronic debit. I agree to reimburse AFFCU for any loss it sustains in honoring this request.

I authorize a one-time fee of \$15.00 to be charged to the account referenced above for this Stop Payment Request

Signature

Date

Please return promptly via Fax or Mail

**Atlantic Financial FCU
40 Schilling Road
Hunt Valley, MD 21031
Fax 410-584-8061**

40 SCHILLING RD
HUNT VALLEY, MD 21031

410.584.7474
1.800.505.7476
FAX 410.584.8061

Office Use Only

Received by _____ Date _____
Charged Waived