WINTHROP
UNIVERSITY HOSPITAL EMPLOYEES
FEDERAL CREDIT UNION

SHARE DRAFT STOP PAYMENT FORM

NAME_____

ADDRESS_____

CITY, STATE, ZIP CODE_____

PHONE NUMBER_____

MEMBER ACCOUNT #_____

CHECK TO STOP_____

AMOUNT_____

1. I request the Credit Union to stop payment on the share draft / money order described above. I warrant that the item description, including the date, its exact amount, the item number, and payee are correct. I understand that the exact information on the item is necessary for the Credit Union's computer to identify the item. If I give the Credit Union the incorrect amount or any other incorrect information, the Credit Union will not be responsible for failing to stop payment on the item.
2. Stop Payment Order. I agree that the Credit Union will not be responsible for stop payment unless my Stop Payment Order is received by the Credit Union within a reasonable time for the Credit Union to act on my order prior to the final payment.
3. Indemnification. I agree to indemnity and hold the Credit Union harmless from all cost, including attorney's, (to the extent permitted by law) damage or claims related to the Credit Union's action in refusing payment of the item, including claims of any joint owner, payee, or endorsee, or in failing to stop payment on an item as a result of incorrect information provided by me.

I HAVE READ THE DISCLOSURE AND TERMS AND CONDITIONS ABOVE. I AGREE TO THESE CONDITIONS, AND HERBY AUTHORIZE WINTHROP UNIVERSITY HOSPITAL EMPLOYEES FEDERAL CREDIT UNION TO PROCEED WITH THIS STOP PAYMENT REQUEST.

_____ _____ **MEMBER**

SIGNATURE DATE

_____ _____ **CREDIT UNION**

REPRESENTATIVE DATE