MEMBER SHARE DRAFT (Checking) STOP PAYMENT REQUEST ORDER

Today's Date _____ Time _____a.m./p.m. Contact me at: _____ Account Number _____ Account Type _____X_____ Consumer _____ Business Account Name __ _____ Payable To _____ _____ Transaction Amount $_____ Check(s) Serial No.__ _____ Date Check(s) Written_____ * Reason for Stop Payment _____ ***(NOTE STOPS PLACED ON CHECK WRITTEN ONLY IF LOST OR STOLEN) _X__Stop Payment for Check – Terms and Conditions**

On the terms hereinafter set out, the undersigned account holder hereby instructs __CT Labor Dept FCU_____ (financial institution name), hereinafter called "the Financial Institution", to stop payment on the above transaction. The stop payment order shall remain in effect for six months.

A charge, as reflected, will be assessed to the account holder as payment for implementing this order. Fee Assessed **$____20.00_____**

By directing the Financial Institution to stop payment on the above transaction(s), the account holder agrees to hold the Financial Institution harmless against any and all loss, claims, damages, and costs, including court costs and attorney's fees, that the Financial Institution may suffer or incur by reason of non-payment of the above transaction if presented prior to withdrawal of these instructions or expiration thereof.

The account holder understands that the stop payment request must be received at least three (3) business days before a scheduled debit(s) or in time to give the Financial Institution reasonable time to act upon it.

The account holder also understands that it is necessary to provide the correct information related to the transaction(s) and that failure to do so may result in the payment of the above items(s). The account holder agrees to hold harmless and indemnify the Financial Institution for all expenses, costs, and damages incurred by payment of the above item(s) if such payment is the result of failure of the account holder to meet the time requirements noted above, or if such payment is the result of failure of the account holder to furnish any item of information requested above completely, accurately and correctly.

Date: Account Holder Signature Print Name

Date
:

Financial Institution Representative Signature Print Name

FOR FINANCIAL INSTITUTION USE ONLY

Manager Approval _____ by_____ Signed Stop Payment Request Form Received on _____ by _____ Written Confirmation of Revocation Received on _____ by _____