



## SHARE DRAFT STOP PAYMENT REQUEST FORM

Today's Date: \_\_\_\_\_

I, the undersigned, hereby request and authorize the Healthcare Employees Federal Credit Union to stop payment on the following share draft (check) listed below:

Share Draft Account #: 269 \_\_\_\_\_  
Draft #: \_\_\_\_\_  
Payable to: \_\_\_\_\_  
Amount: \_\_\_\_\_  
Date of Draft: \_\_\_\_\_  
Member's Name: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Note: There may be a fee to place a stop payment on one check or a range of checks. Please be sure to ask your representative if any fees will apply.***

***A stop payment will take effect 24 hours after receipt of this request form.***

***A stop payment expires six months from date above.***

***Please call to verify receipt of this fax.***