



# Stop Payment Request

Greensboro Municipal Credit Union  
 217 N. Greene Street  
 Greensboro, NC 27401  
 Institution (“We” or “Us”)

**To Submit:**

1. Fill out the form
2. E-Mail, Fax or Phone your Stop-Payment Request to a Member Service Representative.
3. You must come in and sign the form within 14 days or the stop-payment will be rescinded.

**You may forward your Stop Payment request via phone, fax or E-mail, Attn: Member Services**

|                |                       |                     |                             |
|----------------|-----------------------|---------------------|-----------------------------|
| Sharon Boone   | Phone: (336) 373-2392 | Fax: (336) 373-5896 | Sharonb@greensboromcu.org   |
| Darlene Wilson | Phone: (336) 373-2902 | Fax: (336) 335-5556 | darlenew@greensboromcu.org  |
| Karen Caviness | Phone: (336) 373-7985 | Fax: (336) 335-5556 | kcaviness@greensboromcu.org |

**IMPORTANT: Item Description:** Because of the large volume of items we process, we do not visually inspect each item. We use a computer system. **Therefore, every one of the item descriptions indicated by a “☒” must be EXACT or our computer system will not be able to identify the item, making this Stop-Payment order ineffective.**

|   |  |                                       |                          |
|---|--|---------------------------------------|--------------------------|
| Request Received:   | Amount of Item:                              | <input type="checkbox"/> Check Number | Date: _____              |
| <input type="checkbox"/> In Person <input type="checkbox"/> _____ | <input type="checkbox"/> Exact to the penny  | <input type="checkbox"/> Payable to:  | <input type="checkbox"/> |
| <input type="checkbox"/> By Phone                                 | <input type="checkbox"/> Exact to the dollar | _____                                 |                          |

Account Name: \_\_\_\_\_ Address: \_\_\_\_\_

E-mail address Home: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail address Work: \_\_\_\_\_

**You and we will abide by the rules and regulations (as established by the Uniform Commercial Code or other law) governing Stop-Payment orders. To be effective, we must receive the Stop-Payment Order in time to give us a reasonable opportunity to act on it, and before our stop-payment cutoff time, if any. Oral Stop-Payment Orders (including by phone) are binding for 14 DAYS ONLY, unless you confirm the order in writing on the proper form with the 14-day period. Properly signed Stop-Payment Orders are effective for 6 months after the date accepted and will automatically expire after that period unless renewed in writing.**

\_\_\_\_\_  
 Authorized Signature (“You” or “Your”)

**Credit Union Use Only**

|                                    |                   |  |         |
|------------------------------------|-------------------|--|---------|
| Request Received:                  | Request Accepted: | Account Number   | Other : |
| <input type="checkbox"/> In Person | Date: _____       | _____  | Number  |
| <input type="checkbox"/> By Phone  | Time: _____       | Duplicate Issued:  | Date:   |
| <input type="checkbox"/> _____     | By: _____         | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____   |

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