

STOP PAYMENT REQUEST



LCFCU.ORG | 202-707-5852 | 800-32-LCFCU (52328) | 800-325-2328



SERVICE FEE WHICH WILL BE **CHARGED** TO YOUR ACCOUNT. **DATE** ____/____/____

ACCOUNT NUMBER _____ AMOUNT: \$ _____
MEMBER NAME: _____ PAYABLE TO: _____
TELEPHONE : _____ REASON FOR STOP PAYMENT: _____
EMAIL: _____

STOP PAYMENT - CHECK(S)

CHECK(s) Stop Payment — The stop payment request shall remain in effect for SIX MONTHS.

Date Check(s) Written: _____

Individual Check/Draft Number: _____

— OR —

Range of Check/Draft Numbers: _____

STOP PAYMENT - ACH

One-Time ACH Stop Payment — **OR** — Recurring ACH Stop Payment

The stop payment shall **remain in effect until** the earlier of: a) Written notice being received from the account holder to revoke the stop payment order or b) The return of all debit entries.

Expected Item(s) Clearing Date: _____

The authorization was revoked with the ACH Originator on ____/____/____.

— **OR** —

The ACH Originator will be notified to revoke the authorization on ____/____/____.

I hereby agree to hold Library of Congress Federal Credit Union harmless for said amount and to indemnify it against any loss, expenses and costs incurred by reason of its compliance with this stop payment request and further agree not to hold the Credit Union liable on account of payment contrary to this request if it occurs through inadvertence, accident or oversight, or if by reason of such payment other items drawn by the undersigned are returned unpaid. I understand that the stop payment request must be received at least one (1) business day before a scheduled debit(s) or in time to give the Credit Union reasonable time to act upon it. I also understand 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). It is further agreed that the service fee indicated at the top of this form will be assessed to my account as payment for implementing this stop payment order.

I have read this statement in its entirety and attest that the information provided on this statement is true and correct.

X _____
Member Signature

Print Name

Date

I release the Library of Congress Federal Credit Union from its obligation to stop payment on the above transaction(s).

X _____
Member Signature

Print Name

Date

**LCFCU STAFF
USE ONLY**

Signed Stop Payment Request Received (Date/Time) _____ by _____

Signed Confirmation of Revocation Received (Date/Time) _____ by _____

Trace / Company ID _____

Please Fax or Mail your completed form:

- Fax: 202-707-6418
- By Mail:
Library of Congress FCU
8100 Professional Place, Suite 308
Hyattsville, MD 20785-2229

Completed forms can also be dropped off in-person at our Madison branch:

**101 Independence Ave., SE,
Room LM 634,
Washington, DC 20540-9997**