

Member Account Number: _____

Share ID: _____

STOP PAYMENT ORDER

Check #: _____ Amount: \$ _____ Date: _____ Payable to: _____

Check #: _____ Amount: \$ _____ Date: _____ Payable to: _____

Check #: _____ Amount: \$ _____ Date: _____ Payable to: _____

Check #: _____ Amount: \$ _____ Date: _____ Payable to: _____

Check #: _____ Amount: \$ _____ Date: _____ Payable to: _____

Your stop payment request authorizes HVCU to assess a stop payment fee in accordance with our Fee Schedule and establishes agreement with the stop payment terms and conditions described in the Truth in Savings Disclosure and Account Agreement. This order remains in effect for six months unless HVCU receives your 1) written request to cancel the stop payment; or 2) request to extend the stop payment.

Account Holder's Name: _____ Phone: _____

Signature _____ Date: _____

Please FAX signed form to 845-432-3393

CANCEL STOP PAYMENT

Please **cancel** the above stop payment order on check number(s) _____ to _____.

Account Holder's Name: _____ Phone: _____

Signature _____ Date: _____

For Credit Union Use Only: Branch/CC completed by _____