Stop Payment Request

Member Number _____

Please stop payment on the check described herein.

First Name _____ Middle Initial _____

Last Name _____ Date of Request _____

Time of Request _____ Reason for Request _____

_____

Payable to _____ Check Number _____

Amount of Check _____ Date on Check _____

Received By _____

The member agrees to hold harmless MIT Federal Credit Union for all expenses and costs incurred by the member by refusing to pay said item. The member further agrees to allow a reasonable time period for the Credit Union to act on this request before it actually goes into effect. The member agrees that this stop payment request shall remain in effect for six (6) months from the date of request. Also, the member agrees to pay a stop payment fee of $15.00 per stop payment.

Signature _____

Date _____

A copy of this request must be mailed or presented to the member who requests to stop payment.

700 Technology Square Building NE48 Cambridge, MA 02139-3586 T: 617-253-2845 F: 617-258-5709