TEACHERS federal credit union
Smart For All

teachersfcu.org
102 Motor Parkway | Hauppauge, NY 11788

Official Check Stop Payment Request

Please fill out form and bring to a branch or mail to: TFCU, PO Box 9005, Smithtown NY 11787

Date Issued: _____

Check No: _____

Amount: _____

Account No: _____

Member's Name: _____

Payee: _____

I (we) believe that the above described check, which you issued (certified) at my (our) request, has been lost, stolen or destroyed under the following circumstances:

☐ Lost ☐ Stolen ☐ Destroyed

Explanation: _____

_____

and that the check has not been endorsed or transferred except as set forth above. I (we) request you to stop payment of the check without requiring its surrender for cancellation, and to credit the proceeds of the check to my (our) account with you, or instead of such credit to do the following:

☐ Credit Account ☐ Replace Check

If a third party check, explain why the account will be credited: _____

_____

I (we) agree to protect you against and to reimburse you for any costs, damages and/or lawsuits (whether groundless or not) involving the check and any and all losses, damages and/or expenses of every kind that you may incur by reason of complying with this request. I (we) understand that the Credit Union is under no legal obligation to comply with an official check stop payment request within the first 90 days of issuance. If during the 90-day waiting period the original check is presented for payment, the Credit Union is required by law to pay the original check. I agree to reimburse the credit union for this amount, and understand it will be withdrawn from my account if this situation occurs.

I (we) agree to indemnify Teachers Federal Credit Union against all claims, demands, actions, judgements, loss and/or damages, including attorney's fees and court costs, suffered or incurred by TFCU as a result of my request that payment of the above check be stopped. For official check stop payments requests that are received within 90 days of the issue date, the Credit Union will require the payee or endorsee signature to indemnify the Credit Union for any loss or expense resulting from the original check being presented for payment.

I (we) further agree that if the check comes into my (our) possession, it will promptly be delivered to you for cancellation.

Member Signature: _____ Date: _____

Non-Receipt Statement by Payee or Endorsee

TO BE COMPLETED IF A STOP PAYMENT IS PLACED WITHIN 90 DAYS OF ISSUE DATE

I, _____, (print or type name of non-recipient) hereby assert that I did not receive the above described cashier's check, teller's check or certified check and I have not received payment from the above remitter. I therefore request payment for the amount of the original check issued and agree to provide identification if so requested by the Credit Union.

Date Acknowledged:
_____day of _____, 20 _____

_____
Signature of Non-Recipient

Subscribed and sworn to before me this:
_____day of _____, 20_____

_____
(Notary Public)

For Internal Use Only

Employee Signature: _____ ☐ $25 Fee Charged

Branch Name/#: _____

Operator ID #: _____ Initials: _____

Accounting Use Only: Date of Replacement Check: _____

Dept. Approval: _____ Date: _____ CK#: _____

Authorized By: _____ Date: _____ GL Code: _____