STOP PAYMENT FORM

LIFE CREDIT UNION

Account #: _____ Date: _____

Last Name: _____

First Name: _____ Middle Initial: ____

Street Address: _____ State: _____

City: _____ Zip: _____

Work Phone: _____ Email: _____

Home Phone: _____

Check # to Stop: _____ Amount: _____

Payable to _____ Date Written: _____

Disclosure: All items must be accurate or our computer systems will not properly stop payment. This stop payment is good for fourteen days. **You need to print, sign and return this form to create a stop payment that is valid for 180 days** (in person or by mail)

Signature: _____ Date: _____

You Must Print, Sign, and Return to Your Employer

(by mail, fax or in person)

A signature is needed to complete the process

PRINT FORM