HEALTHCARE ASSOCIATES CREDIT UNION
The healthy way to bank®

2441 Warrenville Road, Suite 400, Lisle, Illinois 60532
Call Center: 800.942.0158
hacu.org

ACH Stop Payment Request Form

☐ **New Stop Payment Order** ☐ **Cancel Existing Stop Payment Order**

Member Name _____

Member Number _____

I hereby authorize HealthCare Associates Credit Union to place a Stop Payment on the ACH debit listed below. This order will remain in effect until I have canceled it in writing. I understand that Stop Payments cannot be placed on debits that have already posted to my account. **Please apply the $30.00 Stop Payment Fee to my:**

☐ **Savings** ☐ **Checking**

I understand that the Stop Payment Order will not be placed unless $30.00 is available in my account for the Stop Payment Fee.

Company Name: _____

Description of debit: _____

Date item last paid: _____

(Select one)

☐ Please place a **Permanent Stop Payment** on the ACH debit. Do not pay any future debits from this company.

☐ Please place a **One-Time Stop Payment** on the ACH debit.

Exact amount of ACH debit: _____

Date for one-time Stop Payment Order to expire: _____

Member Signature: _____ Date: _____

Form must be completed in its entirety before the order is processed. If sending the completed form by fax, please send to 630.276.5841.