AdventHealth
Credit Union

STOP PAYMENT REQUEST AND INDEMNITY AGREEMENT

I, _____, certify under penalty of perjury that AdventHealth Credit Union check #_____ issued on _____, 20____, in the amount of $_____ and payable to _____has been lost or stolen.

- ☐ I am the remitter or payee of the check;
- ☐ The check has not been transferred or lawfully seized;
- ☐ The check was in my possession when it was lost or stolen;
- ☐ This request is not made with the intent to commit a fraud, to breach a promise or contract, to gain an advantage in a business transaction, or to cause harm to any person.
- ☐ I cannot return the check to the credit union because it was destroyed, its whereabouts are unknown, or it is in the unlawful possession of an unknown person.

I further request that AdventHealth Credit Union stop payment of the above-described check, and agree as follows:

1. The credit union is fully released from all liability which may result from payment of the check before or a reasonable time after this request is made, from failure to act because of incomplete or inaccurate information, or from stopping the payment of the check after this request is rescinded. Acting upon this request is at the option of the credit union.
2. The credit union may, at its option, delay credit for or refund of the check until 90 days after the check was issued and may thereafter require a written agreement from all parties concerning the disposition of funds or may interplead the funds for disposition by a court having jurisdiction.
3. The request to stop payment will expire after 6 months but may be renewed in writing. This request can only be rescinded in writing, and no rescission is effective unless accepted by the credit union.
4. The check will not be presented for payment by any person while a stop payment request is pending, nor after the check is paid or refunded by the credit union. If the original check is recovered, it will be marked VOID and returned to the credit union.
5. I agree to indemnify the credit union from and hold the credit union harmless against any claim, loss or expense, including court costs and attorney fees before or after a lawsuit is filed, arising from or connected with the credit union fully or partially following this request or my instructions, and arising from or connected with the payment or disposition of the funds, or the timing thereof, in accordance with this agreement.
6. This agreement shall remain in effect and be enforceable for a period of five (5) years after it is signed by me, or one (1) year after the credit union learns of any claim, loss or expense which is indemnifiable, whichever is later. This agreement shall be enforced under the laws of the State of Florida, and the venue of any action, arbitration or mediation shall be Seminole County, Florida, or other venue at the option of the credit union.

_____ _____ _____
Signature of Remitter or Payee Date CU account #

_____ _____
Witness (CU employee) Branch
This request to be notarized or witnessed by a credit union employee.

State of _____
County of _____
Sworn to and subscribed before me on _____, 20____ by _____, who is personally known to me or provided identification:_____.

_____
Notary Public