

COLORADO COMMUNITY BANK

CHECK STOP PAYMENT REQUEST

Check Number:	Check Dated:	Check Made Payable To:	Check Amount:
Reason For Stop Payment:		Replacement Check Issued: ___ Yes ___ No	Replacement Check Number:
Expiration Date:			
Account Number:		Stop Payment Fee:	

Account Name & Address:

****To be effective, the stop-payment request must be received in time to give us a reasonable chance to act on it. ****

Colorado Community Bank and the undersigned agree to abide by the rules and regulations (as outlined in the Uniform Commercial Code) governing Stop-Payment Orders. Oral Stop-Payment Orders (including by phone) are binding for 14 CALENDAR DAYS ONLY, unless the Account Owner confirms the order by signing the proper form within the 14 day period. Properly signed Stop-Payment Orders are effective for 6 months after date received and will automatically expire after that period unless renewed in writing.

Print Name of Initiator of Request: _____

Authorized Signature: _____ **Date:** _____ **Time:** _____

RELEASE OF STOP-PAYMENT ORDER

The above Stop-Payment Order is release as of the date shown below:

Authorized Signature: _____ Date: _____

(Same Authorized Signer as Appears on Stop Payment)

<p style="text-align: center;">INTERNAL USE ONLY</p> <p>Received By: _____</p> <p>Date Rec: _____ Time: _____</p> <p>Request Received: ___ In Person ___ By Phone</p> <p>Inputted By: _____ Verified: _____</p>	<p style="text-align: center;">INTERNAL USE ONLY</p> <p>RELEASE Rec By: _____</p> <p>Date Rec: _____ Time: _____</p> <p>Request Rec: ___ In Person ___ By Phone</p> <p>Inputted By: _____ Verified: _____</p>
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