



1980 W. Broad Street  
 Columbus, OH 43223  
 Phone: 614-466-4988 / 800-434-7300 / Fax: 614-466-5118

**FAX OR MAIL COMPLETED FORM**

**DECLARATION OF LOST, DESTROYED, OR STOLEN CERTIFIED, CASHIER'S, OR TELLER CHECK (AND) REQUEST FOR PAYMENT OF LOST, DESTROYED, OR STOLEN CERTIFIED, CASHIER'S, OR TELLER CHECK.**

**CHECK AND CLAIMANT INFORMATION:**

Name of Claimant: \_\_\_\_\_ Account Number that provided funds # \_\_\_\_\_  
 (or primary share account number if purchased with cash)  
 Date of Check: \_\_\_\_\_ Check Number: \_\_\_\_\_  
 Name of Payee: \_\_\_\_\_ (if different than claimant, if different payee must acknowledge loss)  
 Amount of Check: \$ \_\_\_\_\_

**DECLARATION OF LOSS:**

By my signature below, I certify and declare under penalty of perjury that I am the Claimant named above; that I am making this request and claim, and that I lost possession of the check, and the loss of possession was not the result of a transfer by me or a lawful seizure of the check; and that I cannot reasonably obtain possession of the check because: (check  applicable box)

- 1. The check is lost.
- 2. The check was destroyed\*
- 3. The check was stolen from my possession
- 4. The check is otherwise in the wrongful possession of an unknown person
- 5. The check is in the wrongful possession of the following person who cannot be found: \_\_\_\_\_
- 6. Other: \_\_\_\_\_

\*If the check has been damaged or mutilated, STECU, at its option, may require presentation of the damaged or mutilated item.

**REQUEST FOR PAYMENT:**

I request payment of the amount of the check by STECU in the form of (check one):

- Replacement Check
- Deposit into primary shares, account # \_\_\_\_\_

I acknowledge and agree that the DECLARATION OF LOSS set forth above constitutes a warranty of the truth of statements made in that declaration.

I acknowledge that if the check is presented for payment, STECU is no longer obligated to pay the check. I also agree that if the check is presented for payment by a person having the rights of a holder and is subsequently paid, I am obligated to refund the payment to STECU or pay the amount of the check to the person having the rights of a holder if the check is dishonored.

By signing this declaration and request, I agree to defend, indemnify, and hold harmless from any claim, damage or costs made or incurred as a result of its refusal to pay the check described above.

CLAIMANT'S SIGNATURE \_\_\_\_\_ DATE/SIGNED: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

(A fee of \$25.00 is assessed for each claim request presented less than ten calendar days from date of issuance)

Check # \_\_\_\_\_ has a stop payment placed on it. If you receive this check, write "void" on it and return it to us.

**OFFICE USE ONLY:** STOP PAYMENT PLACED \_\_\_\_\_ FUNDS RETURNED TO ACCOUNT \_\_\_\_\_  
 REPLACEMENT ISSUED, IF APPLICABLE \_\_\_\_\_ (WRITE N/A IF NOT APPLICABLE)