ACH DEBIT STOP-PAYMENT REQUEST

Internal use

(NOT FOR ACH DEBITS INITIATED PURSUANT TO CHECK TRUNCATION PROGRAMS, TRC OR TRX)

Account Number: ______________________________

Account Title: ______________________________

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Check and complete (to the extent applicable) one of the following two choices:

☐ Please stop payment of the single Automated Clearing House (ACH) debit identified below. I (the undersigned) understand that this Stop-Payment Order will not apply to any other ACH debits for the benefit of the Payee/Originator.

Payee/Originator: ______________________________

☐ Scheduled Future Transfer Date ______________________________

☐ Initiated/Authorized by Check/Draft #: ______________________________

Dated: ______________________________

Amount: ______________________________

☐ Please stop all future ACH debits pursuant to the authorization identified below, including but not limited to recurring preauthorized payments. I understand that I am required by the Institution to confirm in writing that I have revoked the authorization given to the Payee/Originator, and by signing this Stop-Payment Order I do so confirm.

Payee/Originator: ______________________________

Date of Authorization: ______________________________

Description of Authorization: ______________________________

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Institution Name ______________________________

Received By ______________________________

Date Received ____________ Time ____________ M. Fee $____________

Request Received: ☐ In Person ☐ By Phone ☐ ____________

To be effective a Stop-Payment Order must be received in time to allow the institution a reasonable opportunity to act on it, and for some ACH debits must be received at least three banking days before the scheduled date of transfer. To be effective a Stop-Payment Order also must identify the payment sufficiently to allow the institution a reasonable opportunity to act on it. IF THE INSTITUTION GIVES NOTICE AT THE TIME AN ORAL STOP-PAYMENT ORDER IS RECEIVED THAT WRITTEN CONFIRMATION IS REQUIRED AND PROVIDES AN ADDRESS WHERE THE WRITTEN CONFIRMATION CAN BE SENT, an oral Stop-Payment Order is effective for 14 calendar days only, unless confirmed in writing within the 14-day period. The institution and the undersigned agree to abide by the ACH rules and regulations regarding Stop-Payment Orders.

Authorized Signature X ______________________________

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Initials: ____________

NOTICE:

If you wish to withdraw the Stop-Payment Order described on page 1, please sign below and return this form to the Financial Institution so we may remove the Stop-Payment Order from our records.

The Stop-Payment Order on page 1 and any revocation of the authorization identified on page 1 are withdrawn.

Authorized Signature ________________________ **Date** ____________

(Withdrawal should bear same authorized signature as stop order.)

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