

ACH DEBIT STOP-PAYMENT REQUEST

Internal use

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

Account Number: _____
Account Title: _____

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: _____

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 _____

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of the authorization identified on page 1 are withdrawn.**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.)**