

# STOP PAYMENT FORM



Account #: \_\_\_\_\_

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_

State: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Check # to Stop: \_\_\_\_\_

Amount: \_\_\_\_\_

Payable to \_\_\_\_\_

Date Written: \_\_\_\_\_

Disclosure: All items must be accurate or our computer systems will not properly stop payment. This stop payment is good for fourteen days. **You need to print, sign and return this form to create a stop payment that is valid for 180 days** (in person or by mail)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**You Must Print, Sign, and Return to Your Employer**

(by mail, fax or in person)

A signature is needed to complete the process

**PRINT FORM**