Stop Payment Request

Financial Institution_____ Received By_____

Request Received ___In person ___By phone Date received_____ Time_____

(ACH or CHECK) Item Number_____ Item Dated_____

Item Payable To_____Item Amount_____

Replacement Item Issued (Y or N) Item Number_____ Date_____

Fee $_____

Account Name_____Account Number_____

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

This Financial Institution 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.

_____

Name of initiator of request (Please Print)

X_____

Authorized Signature Date Time

Release of Stop Payment Order

The above Stop Payment Order is released as of the date shown below.

_____ _____

Signature (Same Authorized Signer as appears above) Date

Record of receipt of release of the above Stop Payment Order

_____ _____

Signature of Representative of Financial Institution Time and Date