ACH STOP PAYMENT REQUEST

Account Holder Name: _____

Account Number: _____

Originating Company Name: _____

Transaction Amount*: $_____ OR ☐ Any amount.

Check Serial Number: _____ (only for check-related debit entries)

*Please be aware that by selecting a specific amount, the company still has the ability to process additional payments for an amount other than what is indicated on this form. Please carefully consider if you are attempting to stop the company from processing payments altogether or only a specific dollar amount before completing this form. For pre-authorized entries, three business days advance notice prior to the expected transfer date of the debit entry is required to implement the stop payment request. If the stop payment order is received within three business days of the expected transfer date, we will attempt to satisfy the request of the account holder but will not be held liable if sufficient time was not provided for a pre-authorized transfer that occurs within the three business day period. The account holder also understands that it is necessary to provide the correct information related to the transaction(s) sufficient to enable the identification of the account and transaction(s) in question.

_____ **Account Holder initial here**

For all non-recurring, single transaction ACH payments, the stop payment request must be provided in a timeframe that allows reasonable opportunity for us to honor the request prior to finalizing the ACH entry.

Please indicate your specific choice for stopping payment from the Originating Company named above by checking the appropriate box:

☐ **I wish to stop all future payments from this Originator indefinitely**

☐ **I wish to stop the next payment only.**
   Future entries from this Originator are to be paid, unless I provide you with an additional stop payment order

☐ **I wish to stop a series of payment.**
   Identify the payment dates, or months, or the specific payments from the Originator you wish stopped

_____

A fee will be assessed to the account holder as payment for implementing this order:

Fee Assessed: $25

This form acknowledges the account holder's request to stop payment on pre-authorized electronic funds transfers as indicated above. The account holder further represents that the debit transaction(s) described above were not originated with fraudulent intent by me or any person acting in concert with me, and that the signature below is my own proper signature.

_____   _____
Signature   Date

For financial institution use only:
Instructions received by: _____
Date: _____ Time: _____

Please complete and sign this form and return to;
Attn: Account Services Dept. FAX: (866) 496-5134 or EMAIL: account_services@SouthlandCU.org