ACH STOP PAYMENT REQUEST

☐ ACH – ONE TIME STOP PAYMENT ☐ ACH – PERMANENT STOP PAYMENT

☐ WRITTEN REQUEST ☐ VERBAL REQUEST*

DATE: _____ TIME: _____ ☐ A.M. ☐ P.M.

ACCOUNT #: _____ MEMBER NAME: _____

PAYABLE TO: _____ AMOUNT: _____

REASON FOR STOP PAYMENT: _____

NOTE: For verbal request of stop payments, the financial institution will provide this form to the account holder for signature. Oral stop payment orders are binding on Financial Institution for fourteen (14) days only, unless confirmed by you in writing within that period.

The stop payment order shall remain in effect until the earlier of (1) the withdrawal of the stop payment order by the Receiver, or (2) the return of the debit entry, or, where a stop payment order is applied to more than one debit entry under a specific authorization involving a specific Originator, the return of all such debit entries.

I understand the stop payment does not cancel or change the contract I have with the originating company. To cancel that contract and terminate my preauthorized debit, I must follow the specifications outlined in the contract.

You have authorized, directed and requested Financial Institution to stop payment on the transfer(s) described above. You agree to indemnify and hold the Financial Institution harmless from any and all claims, liabilities, costs and expenses, including, but not limited to, court costs and reasonable attorney fees, resulting from the Financial Institution's refusal to pay the transfer(s) described above. Financial Institution shall have no liability to you for the payment of the transfer(s) contrary to this stop payment order if the indicated transfer(s) dollar amount, account number, or other information is not accurate. Financial Institution is not liable to you if it pays the identified transfer(s) if Financial Institution acted in good faith or exercised ordinary care. Any damages that you incur and which the Financial Institution may be liable for are limited to actual damages not to exceed the amount of transfer(s). You agree that the Financial Institution may charge you the fee indicated for processing this stop payment order. Such fee may be deducted from your account.

Click Here To Reset Form

Date: _____ Signature _____

Please Return this form to: PO BOX 8026 WAUSAU WI 54402 or fax to: 715-870-2699

I HEREBY DECLARE THAT I WISH TO REVOKE THE STOP PAYMENT ORDER AS DESCRIBED ABOVE.

Date: _____

Signature: _____

Accepted by: _____

FOR FINANCIAL INSTITUTION USE:

Date: _____

Accepted by: _____

☐ Fee Assessed: $_____

There is no warranty, expressed or implied, in connection with making this form available. WACHA-The Premier Payments Resource is in no way responsible for any error or omission in this form. This form was devised in accordance with the ACH Operating Rules. Further clarification may be obtained from legal counsel. Bolded sections on this form are optional. Financial institution should verify their policy to determine if these sections should be deleted.