



Stop Payment Request Form

Social Security Number, Printed Name, Week Ending Date, Check Date, Reason for Stop Payment, Signature and Date MUST BE FULLY COMPLETED ON THIS FORM TO INITIATE THE STOP PAYMENT PROCESS.

SSN # _____

DATE: _____

I, _____, AUTHORIZE

(PLEASE PRINT NAME ABOVE)

ARNOLD TRANSPORTATION SERVICES TO PLACE A STOP PAYMENT ON MY CHECK -WEEK ENDING _____ /CHECK DATED _____ AND ISSUE A REPLACEMENT CHECK.

UPON RECEIVING THIS REQUEST A REPLACEMENT CHECK WILL BE ISSUED AFTER A 24 HOUR BANK VERIFICATION PERIOD HAS OCCURED. THIS APPLIES TO NORMAL BANKING BUSINESS HOURS ONLY. FOR STOP PAYMENTS REQUESTED ON FRIDAY THE REPLACEMENT CHECK WILL BE ISSUED NO EARLIER THAN THE NEXT BANKING BUSINESS DAY (i.e. MONDAY).

PLEASE BE ADVISED, ONE OF THE FOLLOWING FOUR CHOICES MUST BE CHECKED OR CIRCLED OTHERWISE THE STOP PAYMENT AND REISSUE PROCESS WILL NOT BE INITIATED.

___ **NEVER RECEIVED: LOST IN MAIL**

___ **RECEIVED CHECK: UNCASHABLE/DAMAGED**

___ **RECEIVED CHECK: LOST BY EMPLOYEE**

___ **STOLEN**

SIGNATURE: _____

Return to Payroll

or Fax to

Arnold Transportation Services
451 Freight Street
Camp Hill, PA 17011

1-717-730-0930