



STOP PAYMENT REQUEST FORM

409 Silverside Road, Suite 105
Wilmington, DE 19809
P: 866.902.0356
F: 302.385.5194
www.thebancorpha-eb.com

I authorize the The Bancorp HSA to place a Stop Payment on the Check(s) or ACH Debit transactions described below.

By signing this document, I assert that all the information provided below is accurate to the best of my knowledge. If the item is presented in a different method or amount than I have indicated, the payment may still be issued with no liability to The Bancorp Bank (Bank).

The Stop Payment request will remain in place for six (6) months, unless I choose to revoke it in writing. According to Delaware law, Stop Payment Orders not confirmed in writing and received within 14 days are non-binding upon the Bank. I further affirm that, should I wish to maintain the stop payment for up to six (6) more months, I understand that I will need to submit a new Stop Payment form and in doing so, an additional service fee will be assessed to my account.

At your request, we have stopped payment on the check described below. Our records do not disclose that this order has been confirmed. If you wish it to remain in effect, please sign and return this copy to the Stop Payment Department. According to Delaware law, Stop Payment Orders not confirmed in writing within 14 days are not binding upon the Bank.

PART 1: Personal Information

Account Holder's Name:	Account Number:
Address:	Contact Phone Number:

PART 2: Stop Payment: Check Information

WE CANNOT ACCEPT RESPONSIBILITY FOR STOPPING PAYMENT ON A CHECK UNLESS WE HAVE BEEN GIVEN THE EXACT AMOUNT AND CHECK NUMBER.

Check Number: (or check range)	Amount:
Check Date:	Payee:
Reason for Stop Payment:	
Replacement Check Issued: <input type="checkbox"/> Yes <input type="checkbox"/> No	Replacement Check Number: (if applicable)

PART 3: Stop Payment: ACH Information

Stop Payment requests must be provided to the Bank at least three (3) business days prior to scheduled date of the transaction.

WE CANNOT ACCEPT RESPONSIBILITY FOR STOPPING PAYMENT ON AN ACH DEBIT UNLESS WE HAVE BEEN GIVEN THE EXACT AMOUNT, EXPECTED DATE AND PAYEE.

Payee:	Exact Amount of ACH:*	
Standard Entry Code:	Company ID:	Individual ID:
Date of Expected ACH Debit:*	Reason for Stop Payment:	
Check One of the Following: <input type="checkbox"/> Cease All Future Payments** <input type="checkbox"/> One-Time Request Only		

*indicates required information

**When requesting to cease all future payments to a specific payee, you must notify the Originator that you revoke your authorization for those payments. You may be asked to provide evidence of the revocation request in order for this stop payment request to remain in effect.

(Part 3 continued on next page)



Stop Payment Request Form

Page 2 of 2

PART 3 (continued from previous page)

In requesting a Stop Payment of this or any other item, the undersigned agrees to hold The Bancorp HSA harmless for all damages, expenses and costs incurred by the Bank resulting from the refusal of payment for said item, and further agrees not to hold the Bank liable, if, by reason of this Stop Payment Order, other items drawn by the undersigned are returned insufficient, or, if the above-described check or ACH debit is paid because the order to enact the stop was not received in sufficient time.

Furthermore, if this Stop Payment order is for all future ACH payments to a specific payee, you acknowledge that you have notified the Originator of those payments to revoke your authorization for such payments. This shall be legally binding upon the undersigned and upon the executors, administrators, successors, or assigns of the undersigned.

PART 4: Signature - Required

Print Name:	Date: (mm/dd/yyyy)
Authorized Signature:	

Please **mail or fax** this completed form to:

The Bancorp HSA
409 Silverside Road, Suite 105
Wilmington, DE 19809
F: 302.385.5194

FOR BANK USE ONLY

Authorized Representative:	Date Received: (mm/dd/yyyy)	Date Processed: (mm/dd/yyyy)
Branch Number:	Account Status:	Account Balance: