gainwell

Stop Payment Affidavit

Email the completed form to ark-financialgroup@dxc.com

Provider Name _____ Provider Number _____

Street Address _____ Requester's Name _____

City/State _____ Zip Code _____ Date _____

Dear Provider:

A request was made by you to issue a replacement for the check described below. An authorized signature is needed on this affidavit before a stop payment can be placed with the bank and a reissued check is processed. Please return this affidavit to Gainwell Technologies at the email address shown above.

Check Number: _____ Check Date: _____ Amount: _____

Please check one of the following statements.

_____ The said check was not received, nor endorsed, nor has any endorsement been authorized by me.

_____ The said check was received and lost, but was not endorsed nor has any endorsement been authorized by me.

_____ The said check was received and lost. It was endorsed as follows:

_____

Remarks: _____

_____

You are hereby authorized to place a stop payment on this check and issue a replacement check. In consideration I hereby agree, if the original check should be presented showing any personal or authorized endorsement, to reimburse you for any loss, claim, wages, or expenses whatsoever in any manner arising therefrom.

_____ _____

Authorized Signature Date

Clerk