DecisionHR

STOP PAYMENT REQUEST

Check Date: _____ Check #: _____ Amount: _____

Employee Name: _____ SS#: _____

Worksite Employer Name: _____

Reason for Stop Payment / Void:

_____

_____

REPLACEMENT CHECK:

Delivery via: ____ Regular Mail ____ Overnight Express ____ 2nd Day Delivery ____ Next Payroll

Delivery Charges to be paid by: ____ Employee ____ Client Company (Check #:_____ Amount: _____)

THERE WILL BE A $35.00 CHARGE FOR ALL STOP PAYMENTS

Stop Payment fee to be paid by: ____ Employee ____ Client Company ____ Other

_____ _____

Employee Signature Date

_____

Employee Name Printed

_____ _____

Supervisor Signature Date

NOTE: Unless otherwise notified, replacement checks are not issued until DecisionHR receives "stop payment" confirmation from its financial institution. DecisionHR will agree to issue a replacement check prior to this confirmation if an authorized representative of the Client agrees to reimburse the amount of the original check to DecisionHR should the original check be paid by the bank.

_____ _____

Authorized Client Signature Date

11101 Roosevelt Blvd. N., St. Petersburg, FL 33716
Phone 727-572-7331 or Toll Free 888-802-7555 Fax 727-572-1314 or Toll Free Fax 866-674-2227 (rev05/12)