Stop-Payment Request

This STOP-PAYMENT REQUEST is for (select one): Myself Ward, for whom I am custodian

Name: ______________________ **SSN:** ______________________

Ward Name: ______________________ **Ward SSN:** ______________________

Address: ______________________ **Home Phone:** ______________________

______________________ **Work Phone:** ______________________

City: ______________ State: ________ **Other Phone:** ______________________

Select Type: 7j Disbursement Dividend Elders Benefits

Reason for Stop Payment: ______________________________________

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- Stop payments will be accepted 30 day after original check date.
- There is a $25.00 fee associated with all requests for stop payment

Through my signature below, I acknowledge my understanding that this stop-payment cannot be cancelled. I acknowledge and accept the $25.00 fee associated with a Stop Payment. If I receive the check I am now placing a stop-payment on, I understand that I should not cash it, and I agree to bring or mail said check to The Aleut Corporation so that the Corporation can issue a replacement check to me. I understand that if I cash a check I have placed a stop-payment on, and if that check should clear the bank and I receive duplicate payment, The Aleut Corporation has the right to withhold future dividend payments until the Corporation has been reimbursed.

Signature: ______________________________ Date: ______________________

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