



## STOP PAYMENT FORM

Date \_\_\_\_\_

Member Number

First Name/s \_\_\_\_\_

Surname \_\_\_\_\_

Phone Number \_\_\_\_\_

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Name of Bill to be Stopped: \_\_\_\_\_

Amount: \_\_\_\_\_

**PERMANENTLY**  **TEMPORARY**

Date to be Stopped: \_\_\_\_\_

Date to be Restarted: \_\_\_\_\_

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Member Signature

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Staff Witness Signature

### OFFICE USE ONLY

CUBECS Supplier Number: \_\_\_\_\_

Authority Number: \_\_\_\_\_

Direct Debit Supplier Number: \_\_\_\_\_

Officers Signature upon completion: \_\_\_\_\_