



MEMBERSHIP DISTRIBUTION  
REQUEST FOR STOP PAYMENT FORM

Date: \_\_\_\_\_ Tribal ID #: \_\_\_\_\_

Full Name: \_\_\_\_\_

If minor, custodial parent or guardian name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

\*\*\*NOTE: Please ensure that your mailing address matches the address on file with Enrollment. If not, the Enrollment Change form must be completed.

What month are you missing? (must be more than 7 days after the check date)

\_\_\_\_\_

WHEN REISSUE IS COMPLETE:

\_\_\_\_\_  
Requestor's Signature

\_\_\_\_\_  
Date

*Questions?*

**Phone:** 360-716-4364 | **Email:** membershipdistribution@tulaliptribes-nsn.gov | **Fax:** 360-716-0304