Arkansas Tobacco Control
Insufficient Fund Notification Form
This form to be used by a Wholesaler or Manufacturer to place or remove a retail location on the Insufficient Fund List.

--------------------------Wholesaler / Manufacturer Information--------------------------

Business Name: ________________________________ Permit No. ______________________
Contact Person Name: ___________________________ Phone #: _______________________
Contact Email: _________________________________________________________________
Business Address: ______________________________________________________________
State: ____________City: _______________________ Zip Code: ________________________

--------------------------Retailer Information--------------------------

Business Name: ________________________________ Permit #. _______________________
Person Responsible: _____________________________ Phone #: _________________
Business Address: ______________________________________________________________
State: ____________City: _______________________ Zip Code: ________________________

--------------------------Insufficient Fund Information--------------------------

Invoice Date: ______________________             Invoice Number: _______________________
Invoice Due Date: __________________             Invoice Amount:_______________________
Date Invoice was considered Past Due or Insufficient Funds were reported: ________________
Amount of Insufficient Funds: $ _______________

☐ Please ADD the above retailer to the Insufficient Fund List
☐ Please REMOVE the above retailer from the Insufficient Fund List. The Invoice was paid on the following date: ________________

Print: ______________________________________ Signature: _________________________
(Wholesale / Manufacturer Representative) (Wholesale / Manufacturer Representative)

Please email form to: ATC.InsufficientFundsList@groups.arkansas.gov

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