

**EMPLOYEE BENEFIT PLAN (IDA)  
WITHDRAWAL REQUEST**

Forward To: 214 W 9<sup>th</sup> Street  
PO Box 420  
Onaga, KS 66521  
P) 800.521.9897  
F) 913.901.4190  
distributions@mainstartrust.com

This Is a New Address

**WILL DISTRIBUTION CLOSE ACCOUNT?**

Yes  No

**Please Print or Type**

**ACCOUNTHOLDER INFORMATION**

Account Name		Account Number	
Address		Social Security Number	
Address		Date of Birth	
City State Zip		Phone Number	

**DISTRIBUTION**

**Checks and/or Securities will be issued to the Plan unless otherwise indicated**

**Withdrawals**

Distributions to be made: Starting Date \_\_\_\_\_  Once  Monthly  Quarterly  Annually  
(MM/DD/YYYY)

Distribution will be issued by check to the Plan unless directed otherwise by the Trustee.

**Cash Amount**

I instruct the custodian to distribute from the above account:

- 1. The entire cash balance
- 2. \$ \_\_\_\_\_ (value of assets requested) - **or** - other \_\_\_\_\_
- 3. The entire account balance

**Securities**

Attach pages for additional securities.

Asset Description	Quantity	Liquidate	Distribute In Kind
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**SIGNATURE**

I certify that I am the proper party to receive payment(s) and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me by the custodian.

\_\_\_\_\_ Trustee Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Trustee Name (please print)