

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

Forward To: 214 W 9th 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)