



Request For Distribution

ONE-TIME DISTRIBUTION

Mail check

True Link Card

Pay by phone

Vendor: _____ Mailing Address: _____

Amount: _____

Type of Distribution (utility, pet expense, phone, reimbursement, etc...) _____

RECURRING DISTRIBUTION

Mail check

True Link Card

Pay by phone

Recurring bill pay requires the beneficiary to change the mailing address on file to:

(Name of Beneficiary)

c/o Arcare Trust Dept.

PO Box 12890

Overland Park, KS 66282

Vendor: _____ Mailing Address: _____

Account Number: _____

Payment Due Date: _____

Payment Start Date: _____ Payment End Date: _____

Type of Distribution (utility, pet expense, phone, reimbursement, etc...) _____

Select One:

Monthly Payments

Estimated Payment: \$ _____

Quarterly Payments

Estimated Payment: \$ _____

Bi-Annual Payments

(Insurance Payments Only)

Estimated Payment: \$ _____

Annual Payments

(Insurance Payments Only)

Estimated Payment: \$ _____

ORDER AN ITEM

Name of Store or Website: _____

Item Description	Item # or SKU	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Beneficiary (please print)

Phone Number

Signature of Beneficiary/Representative

Date