

125 High Street, Suite 1802, Boston, MA 02110 * Phone 800-225-6704 * Fax 617-742-5666

REOUEST FOR SYSTEMATIC WITHDRAWAL PLAN ('SWP')

REQUEST FOR STSTEMATIC WITH	DICTION (DIVI)
CURRENT REGISTRATION: All fields are required.	
Name(s)	Account Number
Address	Social Security Number or Tax ID
Address	Social Security Number of Tax ID
City, State & Zip Code	Phone Number
	-
Email Address	Date of Birth
WITHDRAWAL AMOUNT: \$ (minimum \$50)	
DELIVERY METHOD: Lack (to address of record)	☐ Electronic Funds Transfer (EFT) (complete Bank Information section below)
	(complete Bank Information section below)
WITHDRAWAL SCHEDULE:	
Monthly Quarterly Semi-Annual Annual	
Start Date (mm/yyyy)	
Withdrawal Date (day of the month you would like your withdrawals made)	
BANK INFORMATION:	
☐ Checking Account ☐ Savings Account ☐ Bank Name	
Bank Routing Number Bank Account Number	
Please include an unsigned voided check. Deposit slips will not be accepted. Your bank must be a member of the Automated Clearing House (ACH). Money market accounts or cash management accounts are not eligible for ACH transactions.	
AUTHORIZATION: By signing this form, I (we) authorize the Trust to act upon my (our) instructions believed to be genuine and in accordance with procedures described in the prospectus. I (we) agree that the Trust will not be liable for any loss, cost or expense for acting on these instructions provided the Trust reasonably believes that the instructions are genuine. I (we) authorize debits from my (our) Trust account and credits to my (our) bank account based on my (our) instructions. If a bank credit cannot be made to process a transaction, the Trust will issue a check in its place and amend the delivery method accordingly.	

Signature of Joint Owner

Date

Date

Signature of Owner