

# LCG Community Trust I

## Disbursement Request Form

### Account Information:

Beneficiary's Name: _____
Authorized Representative's Name: _____
Account #: _____

### Office Use Only:

Date Received: ____ / ____ / ____
Approved By: _____
Date of Disbursement: ____ / ____ / ____

### Disbursement Information:

Disbursement Amount Requested: \$ _____
Description: _____
Make Check Payable To: _____
Mail Check To: Address: _____
City: _____ State: _____ Zip Code: _____

### Disbursement Information:

Disbursement Amount Requested: \$ _____
Description: _____
Make Check Payable To: _____
Mail Check To: Address: _____
City: _____ State: _____ Zip Code: _____

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**A copy of an invoice/bill or proof of purchase must be included with each request form.**

I hereby confirm that the requested disbursements are for the sole benefit of the disabled beneficiary of this sub-account.

Signature: \_\_\_\_\_  
Donor/Beneficiary or Authorized Representative

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

***Please Note: Requests may take up to five (5) business days to be processed. Please plan accordingly as the Trust shall not be liable for any late charges incurred.***