Mail to 3601 C Street, Room 216, Anchorage, AK 99503 ~~ Or fax to 1-907-271-1647
Alaska Questions? Call 1-800-645-8465, extension 4 4, or 1-907-271-1410

OMB Control No. 1035-0004 **Expiration Date: 07/31/2013** **Form OST 01-004**

Individual Indian Monies (IIM)
Instructions for Disbursement of Funds and Change of Address
Office of the Special Trustee for American Indians -- http://www.doi.gov/ost/
If you have any questions call OST at: 1 – 888 – OST – OTFM (1–888–678–6836) TOLL FREE NUMBER

1	**IIM ACCOUNT NUMBER OR TRIBAL ID NUMBER** (If Known)	
2	**CURRENT LEGAL NAME OF ACCOUNT HOLDER**	First Full Middle Name Last Suffix (e.g. Jr.)
	OTHER NAMES USED (Maiden or Also Known As, etc.)	First Full Middle Name Last Suffix (e.g. Jr.)
3	**DATE OF BIRTH** (MM/DD/YYYY) **and SOCIAL SECURITY #**	Date of Birth / Social Security Number
4	**CONTACT TELEPHONE NUMBERS and EMAIL ADDRESS**	( ) Area Code Telephone Number; ( ) Area Code Cell Phone Number; Email address
5	**PAYMENT INSTRUCTIONS**	**Select one of the following options:**

☐ **Automatically disburse all of my funds:** I request all of my IIM funds be paid automatically when the account balance reaches the minimum threshold amount.

OR

☐ **Specific instructions to disburse my funds:** I request that my IIM funds be disbursed as follows (check only one box):

☐ **No Current Disbursements** - I request that my IIM funds be held in my account until I provide further instructions.

☐ **One-Time Disbursement** - I request that $_____ be paid to me on _____, (Date) and the balance **be held in my IIM account** until I provide further instructions.

☐ **Scheduled Disbursements of Account Balance** – I request that 100% of the account balance of my IIM funds be paid to me (circle one of the following: **monthly**, **quarterly** or **annually**) starting on _____. (Date)

☐ **Other** - I request that my IIM funds be disbursed as follows: _____

Third Party Payment

Complete the following *only* if you want your payment made payable to someone other than you.

Printed Name of Third Party Payee: _____

Address of Third Party Payee:

_____
Street Address, PO Box, Rural Route Box

_____
Apt. No., Building Name

_____ City _____ State _____ Zip Code

( ) _____
Area Code Telephone Number

Please return this page

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6 METHOD OF PAYMENT

Must select one option.

NOTE: The electronic transfer of your IIM funds to an OST Debit Card or Direct Deposit to your checking or savings account helps to safeguard against lost, stolen or forged checks. In addition, you **will generally** receive your IIM funds quicker with electronic transfer since mail time for a check will vary depending on **the United States Postal Service** and the destination.

☐ **Direct Deposit to Checking Account** ☐ **Direct Deposit to Savings Account**

Banking information – Attach a voided check or provide the following information:

Routing #: _____ Account #: _____

Name on the Account: _____

Financial Institution Name: _____

Contact Telephone Number(s): _____

Financial Institution Address: _____

OR

☐ **OST Debit Card**

OR

☐ **Check**

NOTE: If you want your check to be delivered to an address different than the mailing address set forth in Section 7 below, please provide your check mailing address on a separate paper.

7 MAILING ADDRESS

NOTE: Complete this section even if you are requesting an OST Debit Card or if you are receiving your funds by Direct Deposit.

_____
Street Address, PO Box, Rural Route Box

_____
Apt. No., Building Name

_____ _____ _____
City State Zip Code

☐ **Please check if this is a new address**

8 YOUR SIGNATURE OR MARK

NOTE: Your signature or mark must be witnessed. The witness must complete Section 9.

I certify that the information provided is true and correct.

_____ _____ *
Account Holder Signature or Mark Date

9 WITNESS OF ACCOUNT HOLDER'S SIGNATURE OR MARK

NOTE: The witness must be age 18 or older, and must sign immediately after the Account Holder signs the document in Section 8. **The dates in Section 8 and Section 9 must be identical.**

I, the undersigned, certify that this request was signed in my presence.

_____ _____ *
Witness Signature Date

_____
Printed Name of Witness

Address: _____ (____)_____
Street Address, Apt. No., PO Box, Rural Route Telephone Number

_____ _____ _____
City State Zip Code

THIS SECTION FOR OST USE ONLY	
ACCOUNT NUMBER:	SERVICE CENTER NUMBER:
DISB TICKLER/BCS NUMBER:	CSS NUMBER:

Please return this page

* Dates must be the same

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Paperwork Reduction Act Statement: This information is collected to manage trust fund accounts for account holders. The information is supplied to obtain or retain a benefit, which is ownership of an Individual Indian Monies (IIM) account, by authority of the American Indian Trust Fund Management Reform Act of 1994. It is estimated that responding to the request will take approximately 15 minutes to complete, including the time it takes to gather the information and fill out the form. Your information will be held confidential by the Department, except as described below in the Privacy Act Statement. If you wish to provide comments about the Form, including the accuracy of the burden estimate and any suggestions for reducing the burden, please send them to the Office of the Special Trustee for American Indians, ATTN: Office of Trust Regulations, Policies and Procedures, 4400 Masthead NE, Albuquerque, NM 87109. Note: Comments, as well as the names and addresses of individuals who submit comments, are available for public review during regular business hours. If you wish us to withhold this information, you must state this prominently at the beginning of your comment. We will honor your request to the extent allowable by law. In compliance with the Paperwork Reduction Act of 1995, as amended, the collection has been reviewed by the Office of Management and Budget (OMB). The collection has been assigned a control number and expiration date by OMB. The number is located at the top left corner of the form and the expiration date follows immediately after the control number. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless a valid OMB control number appears on the face of the form.

Privacy Act Statement: This information collection document contains information that is covered under the Privacy Act of 1974, as amended, in the following system of records: OS—02, ~~I~~ndividual Indian Monies (IIM) Trust Funds." The primary use of this information is to manage the collection, investment, distribution, and disbursement of individual and tribal income from Indian land trust funds. Submission of the information is required to obtain the benefit of having an Individual Indian Money account. The Office of the Special Trustee for American Indians will not disclose any record containing such information without the written consent of the respondent except for the following: (1) it is needed to be sent to appropriate agencies, courts or parties for legal actions, (2) to the Dept. of Treasury so that it can make disbursements, (3) to the IRS for legally required reporting, (4) to appropriate agencies or law enforcement bodies concerning a specific potential violation of a statute or regulation, (4) to agencies or appropriate parties in the event of a breach for remediation purposes, (5) or to a party such as Congress to answer inquiries filed by the account holder. Other examples of those who may request this information are: (6) Individual Indian trust account holders, their heirs, guardians, or agents (7) Contractors, but only after ensuring that all provisions of the Privacy Act, the Trade Secrets Act, the Indian Minerals Development Act, and all other applicable laws, regulations, and policies relating to contracting and security are met, who:

(a) provide trust and other services to beneficiaries;
(b) provide, use, operate or facilitate various components of the system;
(c) service and maintain the system for the Department.

Collection of your Social Security Number is authorized by 31 USC 7701.

No need to return this page