HORIZON TRUST

BILL PAY REQUEST
Self-Directed Retirement Accounts

(888) 205 - 6036 (505) 212 - 0494 operations@horizontrust.com
Horizon Trust Correspondence, PO BOX 27068, Newark NJ 07101

PART 1. ACCOUNT OWNER INFORMATION

First Name: | M.I.: | Last Name: | Account #:

Last 4 SSN Digits: | Date of Birth: *(MM/DD/YYYY)* | Email Address:

PART 2. EXPENSE PAYMENT INFORMATION

○ New or Additional Setup ○ Replaces Existing Payment ○ Stop or Cancel Existing Payment

Expense Description

Asset Name / Description: | Asset Reference #: | Ownership %: *(If less than 100%)*

Memo / Reference Information:

! Please include a copy of the invoice for the asset.
! Ensure invoice has asset name or address listed matching your Horizon profile

Expense Frequency

○ **Option 1. One-Time Payment** *(Complete the following information.)*

Payment Amount: **OR** ☐ Pay amount on attached invoice.

○ **Option 2. Blanket Authorization** ! If the account has sufficient funds, make payments as invoices are received.

○ **Option 3. Recurring Expense** *(Complete the following information.)*

Payment Amount: | Start Date: *(MM/DD/YYYY)* | End Date: *(MM/DD/YYYY)* ☐ Check if no end date.

Payment Occurrence: ○ Monthly ○ Quarterly | Month to Begin: | Process Payments on: ○ 1st ○ 15th

! **IMPORTANT:** Recurring expense payments must be for the same amount each period and must be paid to the same payee. We require written notification if the payment needs to be changed or canceled. To ensure that this expense payment request will be processed by your selected start date, 1) you must have funds in your account, and 2) we must receive this bill pay request no later than 10 business days before the selected start date.

PART 3. PAYMENT METHOD

Please select how you would like funds sent for your payment:

☐ **Option 1. Check** *(See current Fee Schedule for applicable fees.)*

Send check via: ◯ Regular Mail ◯ Overnight Mail *($50.00)* ◯ Cashier's Check + Overnight Mail *($65.00)*

Payee Name: | Payee Tax ID #: *(If applicable)*

Payee Address: | City: | State: | Zip:

☐ **Option 2. Wire or ACH** *(See current Fee Schedule for applicable fees.)*

Bank Name: | Phone:

☐ Check here if separate wiring instructions or additional information is attached.

Payee Name: *(On bank account)* | Payee Tax ID #: *(If applicable)*

Payee Address: | City: | State: | Zip:

Account #: | Type: ◯ Checking ◯ Savings | ABA (Routing) #: | Type: ◯ Wire ◯ ACH

! If the ABA routing number provided accepts both wire and ACH transaction and the box above is not checked, funds will be sent as a wire. If the ABA routing number provided is not for a wire account, funds will be sent as an ACH.

PART 4. ACCOUNT OWNER AUTHORIZATION

I understand this is a self-directed account meaning that I am solely responsible for the selection, due diligence, management, review, retention and liabilities of all investment(s) and for the accuracy of the instructions provided to the Custodian or Administrator to fulfill those investments. I understand the Custodian and Administrator are not fiduciaries and do not provide investment, tax or legal advice.. I acknowledge and confirm that I have received, read, and understand each of the disclosures for my account(s) and direction(s) of investment, and consent and agree to the terms and conditions contained therein. I direct the Custodian to execute the payment of the above-referenced expense for the benefit of my account. In directing the expense payment, I acknowledge and represent that the expense was incurred by my account, that the account is paying only its portion of the expense, and that any person/entity that has provided services relating to the expense is an unrelated third party and not a disqualified person as defined by Internal Revenue Code Section 4975. I further acknowledge that no portion of the expense payment will be used to reimburse me for any expenses paid out of pocket. I agree to hold the Custodian harmless from any liability for any loss, damage, injury, or expense that may occur as a result of the execution of this Bill Pay Request authorization. I understand that the custodian requires a reasonable amount of time to complete my instructions. I understand that I am required to maintain a minimum balance of $500.00 in my account. I further understand that if my request would cause my account to drop below this required minimum balance, the request may not be processed.

Signature of Account Owner: | Account Owner Name: *(Print or Type)* | Date: *(MM/DD/YYYY)*