ACCOUNT CLOSURE FORM
ARKANSAS STATE TREASURY MONEY MANAGEMENT TRUST

Please complete this form and return to the Arkansas State Treasury's Office via email.
Email: MMTrust@artreasury.gov
Contact: STMMT Administrator (501-682-1419)

Please check the box below (one choice) indicating the desired method of closure. A new form must be completed for each trust account affected. Authorization shall be indicated by an original signature on the bottom of this form by the signature of the participant's authorized individual.

Participant Name: _____

Closure Request Date: _____

Participant's Mailing Address: _____

Participant's City, State, and Zip: _____

Participant's Phone Number: _____

Participant's Email: _____

Account Number to Close: _____

- ☐ Check here to transfer all monies into another STMMT account for the same participant.
  OR
- ☐ Check here to inactive an STMMT account and transfer all monies within to the participant's designated bank account on file, by ACH withdrawal.

The signature below, by an authorized individual of this participant, will hereby authorize the State Treasurer to update the account files with the above information.

Authorized by:

_____ _____
Signature ***Title***

_____ _____
Please Print Name ***Date***