



JOHN R. ASHCROFT
 SECRETARY OF STATE
 STATE OF MISSOURI

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 STATE INFORMATION CENTER
 (573) 751-4936

SECURITIES
 (573) 751-4136

THIS FORM IS ONLY FOR THOSE FILING A NOTICE PURSUANT TO MO. REV. STAT. §§ 409.600 – 409.630. PLEASE MAKE ALL OTHER COMPLAINTS AT THE FOLLOWING LINK: [Complaint Form](#)

Notification Pursuant to the Senior Savings Protection Act (Mo. Rev. Stat. 409.600, et seq.)

Directions

Please complete the following questions with as much detail as possible. This allows our staff to gather and analyze the most pertinent information in assessing this notification and a possible enforcement action.

Filer/Reporter Information

Your name: _____ Title: _____

Employer/Affiliated Brokerage Firm: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ E-mail address: _____

Type of Notice

Is this a notification that financial exploitation of a qualified adult (i.e. an adult aged 18-59 with a disability or an adult age 60 and above) has occurred, has been attempted, or is being attempted? _____

Who will you notify or have you notified about the suspected financial exploitation of the qualified adult? Please enter the name, titles, relationship to the victim, and contact information of each individual and/or agency in the space provided below:

Have you refused a request for a disbursement or will you refuse a request for a disbursement? If so, provide the date upon which that refusal occurred or will occur.

Qualified Individual Refusing Request for a Disbursement

Name: _____ Title: _____

Employer/Affiliated Firm: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ E-mail address: _____

Broker-Dealer Agent Information

Name of Qualified Adult's Agent: _____

Address of Agent: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ E-mail address: _____

Supervisor's Name: _____

Qualified Adult (Suspected Victim)

Name: _____ Date of Birth: _____

Gender: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: () _____ Cell Telephone: () _____

E-mail address: _____ Other: _____

Please provide any information – including contact information – regarding all parties authorized to transact business on the account, immediate family members, person(s) with a power-of-attorney, guardians, conservators, co-trustees, successor trustees, and/or those holding a similar legal status with regard to the potential victim:

Person Suspected to have Engaged in the Financial Exploitation

Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ E-mail address: _____

Relationship to Victim: _____

Refusal of the Requested Disbursement (Financial Transaction)

Who requested the disbursement (financial transaction)? _____

Amount of funds requested: _____

Where were the funds to be sent? _____

In connection with the requested disbursement, was or would there be any sale of securities from the account of the qualified adult or an account on which a qualified adult is a beneficial owner? _____

Please provide a detailed explanation of why the qualified individual believes that the requested disbursement will result in financial exploitation. Provide the names and contact information of all relevant parties not previously indicated:

Other

Please provide any other additional information you feel is pertinent to this notification:

Please be advised that the Missouri Securities Division and the Department of Health and Senior Services are prohibited by law from giving you legal advice, legal opinions, or acting as your private attorney. Therefore, you may wish to consult with a private attorney to discuss your legal rights and remedies.

If you have any question about this form, please call the Missouri Securities Division investor hotline at 1-800-721-7996 and/or the Department of Health and Senior Services Adult Abuse and Neglect Hotline at 1-800-392-0210.

Please mail all correspondence to Office of the Secretary of State Securities Division P.O. Box 1276, 600 W. Main St. Jefferson City, MO 65102. Please e-mail hlstate@health.mo.gov for co-investigation as necessary.

Please sign and date to indicate the accurate filing and understanding of this form:

Sign: _____ Date: _____