

The Premier Advantage Retirement Plan Distribution Request Form

Our records indicate that you have not recently made a contribution to the Plan. If you have separated from service or retired from an employer that sponsors a Deferred Compensation Plan, then you may be entitled to a distribution. If so, please complete and return this form. If your employment status has changed from part-time to full-time, your funds may not be released until you have discontinued contributions to this plan for two years or terminate employment.

Please note that your benefit must be distributed no later than April 1 of the calendar year following the date you reach age 70 1/2 or actually retire. If you are already over age 70 1/2 and no longer working for this entity, you must complete and return this form. Failure to satisfy this requirement may result in an excise penalty tax.

If you are still employed as an active part-time, temporary or seasonal employee, you are not entitled to a distribution at this time.

Employee Section

Plan Sponsor: **Mabank Independent School District**

Contract No. **GUET**

Participant:

A

Name: _____

SSN: _____

Address: _____

Telephone #: _____

Date of Birth: _____

Will distribution be sent to the address above: Yes No

If no, enter correct address (please print): _____

Beneficiary or Alternate Payee (only for payment to other than participant). Please Print!

Name: _____ SSN: _____

Relationship to Participant: _____ Date of Birth: _____

Address: _____

Instructions

- Please read the *Notice of Federal Tax Treatment* carefully before completing this form. It contains important tax-related information.
- Please verify information in the *Employee Section*.
- Please complete and sign *Distribution Request Section*.
- Please return the *Distribution Request Form* to MidAmerica Management, Inc., P.O. Box 5666, Lakeland, Florida 33807-5666.

Distribution Request Section

Note: If your account balance is less than \$5,000, you will receive your benefit in the form of a lump sum regardless of the form of benefit you choose.

I, the payee make the following distribution election (choose 1, 2, 3 or 4):

B

1. _____ A direct rollover of the entire account balance to the IRA, 457 plan, annuity plan, or qualified plan designated in Part C of this Section.
2. _____ A direct rollover of \$ _____ or _____ % (not less than \$200) of my account balance to the IRA, 457 plan, annuity plan, or qualified plan designated in Part C of this section, with the balance paid in a lump sum (less 20% federal tax withholding, if taxable distribution is in excess of \$200).
3. _____ A lump sum of my entire account balance (less 20% federal tax withholding, if taxable distribution is in excess of \$200).
4. _____ I elect not to take a distribution at this time.

C

Direct Rollover Information (IRA account, 457 plan, annuity plan, or qualified plan information)

Payee must complete this section only if you checked line 1 or 2 of Part B (check will be made payable to the IRA account, 457 plan, annuity plan, or qualified plan listed below). I represent that the IRA, 457 plan, annuity plan, or qualified plan designated below is a proper recipient plan for a direct rollover. **Please print!**

Name of IRA, 457 Plan, Annuity Plan, or Qualified Plan _____ Account No. _____

If IRA, Name of Trustee, Custodian, or Insurer _____

Name of Payee ("FBO" - For the Benefit Of) _____

Address to Send Direct Rollover _____

City, State, Zip Code _____

D

I acknowledge that the option selected in Part B of this section cannot be paid to me or to my IRA, 457 plan, annuity plan, or qualified plan sooner than 30 days from the date I received this Distribution Request Form and the Notice of Federal Tax Treatment. I understand that I should consult my professional tax advisor about this distribution due to the complexity of the tax laws. I certify that my Social Security number shown on page one of this Distribution Request Form is my correct tax payer identification number and that my full legal name is provided in the Employee Section. I understand that this election supersedes any previous election made under this plan.

Participant Signature _____

Date _____

Employer Authorized Signature _____

Date _____

General Section

Please verify employer's name (top of form) and all personal information. If any of the information is incorrect or if you have already completed one of these forms, please call MidAmerica Management at 1-800-430-7999.