APPLICATION FOR BENEFITS

Plan Name: ____________________

1. Name: ____________________ Social Security No.: ____________________

   Address: ____________________ Date of Birth: ____________________

   ____________________ Date of Hire: ____________________
   City State Zip

2. Reason for Payment

   - ☐ Termination of employment, including retirement - **Effective Date:** ____________ **(date must be provided)**
   - ☐ Death - **Date of Death:** ____________ **(date must be provided)**
   - ☐ Disability - **Date of Disability:** ____________ **(date must be provided)**
   - ☐ Attainment of age 70½ (required minimum distribution)
   - ☐ Qualified Domestic Relations Order (copy of QDRO must be attached)
   - ☐ Termination of Plan
   - ☐ In-Service Withdrawal – Dollar Amount Requested: $____________

3. Type of Payment

   ☐ Cash Distribution: ____________% of Distribution or $____________

   Mandatory 20% withholding applies. Indicate below if you want additional federal taxes withheld.

   Additional Federal taxes withheld:____________% of Distribution or $____________

   ☐ Rollover to: ☐ IRA Account ☐ Qualified Retirement Plan

   Rollover Distribution: ____________% of Distribution or $____________

   Make Check Payable to:____________________

   Account Number: ____________________

   Address: ____________________

   ____

   ____
   City State Zip

NOTE: It is your obligation to insure that the Employer Plan named above will accept the transfer of your benefit payment. Also, only taxable monies may be rolled into another Plan or an IRA. Any non-taxable monies (after-tax) will be distributed to you. If you choose a direct rollover of your benefit, generally you should direct it to only one eligible retirement plan or IRA.

FOR OFFICE USE ONLY

	GROSS AMOUNT ____________	MAIL WITH ATTACHMENT ____________
ACCOUNT NUMBER ____________	LESS LOAN ____________	COPY OF CHECK ____________
VESTING ____________	TAXES ____________	PREPARED BY: ____________
	FEE ____________	APPROVED BY: ____________
	NET PAYMENT ____________	OTHER ____________

4. **Certification**

I have received the "Rollover Distribution (4102(f)) Notice" provided to me by the Plan Administrator. I hereby request payment from the plan in the manner indicated. I hereby waive my right to a 30 day-period in which to consider the decision of whether or not to elect a direct a rollover.

I certify under penalties of perjury that all information provided by me is true and accurate, and that no tax advice has been given to me by the Plan Administrator and/or Plan Sponsor and that all decisions regarding this withdrawal are my own. I expressly assume the responsibility for any adverse consequences which may arise from this withdrawal and I agree that the Plan Administrator and/or Plan Sponsor shall in no way be responsible for those consequences.

X____ ____________________
Signature of Participant Date

Please return the completed form to your Plan Administrator/Human Resources Representative at your company for signature. First Midwest cannot accept Application of Benefit Forms directly from plan participants. Your request will be processed within 5 – 7 business days from the date of receipt. PLEASE NOTE THERE IS A $25 PROCESSING FEE ON ALL DISTRIBUTIONS.

X____ ____________________
Signature of Plan Administrator Date

Application of benefits form must be signed by the assigned plan administrator of the company before distribution is processed.