

APPLIED PLAN ADMINISTRATORS LLC
30600 TELEGRAPH ROAD SUITE 1130
BINGHAM FARMS, MI 48025
248-645-6145 Fax 248-642-2036

SEPARATION OF ACTIVE EMPLOYMENT REQUEST FOR DISTRIBUTION FORM
Please fill out completely and fax to: Applied Plan Administrators LLC
Fax: 248 642-2036

Employer Information

Employer: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Contract # _____ Asset Company _____

Employee Information

Name of Employee: _____ SS#: _____
Date of Birth: _____ Date of Separation/Severance: _____ Date of Hire: _____
Employee Mailing Address: _____
Street City State Zip
Employee Fax#: _____ Confidential Fax? Yes No
Email Address: _____ Tel. No: _____
Check to be mailed to Home Address: Yes No Other: _____
If Rush delivery is required, please indicate Overnight Shipping # _____

Reason for Distribution:

RETIREMENT

The participant is no longer actively employed with the company and has reached the plan's early or normal retirement age as provided in the Plan document.

DEATH OF PARTICIPANT

Please forward a certified copy of the death certificate and the beneficiary form along with this request.

PERMANENT DISABILITY

Please forward documentation of the disability from the attending physician with this form.

TERMINATION OF EMPLOYMENT

The participant is no longer employed with the company for a reason other than retirement, death, or disability.

Final Hour Information for Participant:

Number of Hours this Participant worked during this Plan Year: _____ Hours

Did this Participant work less than 1000 Hours in any other Plan Year of Employment?

NO YES – During the following plan years: _____

Waiver of minimum notice period: I consent to an immediate distribution of the elected portion of my vested account balance. I affirmatively waive any unexpired portion of the minimum 30-day notice period during which I may consent to a distribution from the Plan.

I understand that the Plan Administrator will process my request within a reasonable time, and I agree to provide any additional information which the Plan Administrator may require. I also agree to pay Applied Plan Administrators LLC for any processing fees for this distribution. (Please contact your Employer for the current amount of distribution processing fees)

Participant

Date

Plan Trustee

Date

Plan Trustee - Please sign to verify the Employee Information, Reason for Distribution and Final Hour Information stated above is complete and accurate and to authorize APA to process this Request for Distribution. Please fax completed and signed form to: 248 642-2036.

NOTE:

Distribution Fee: **\$35.00** due upon return of this Distribution Request Form unless automatically deducted from your account.