

## 457(b) Distribution or Rollover Request

Complete this form to request a distribution or a rollover from your current or former employer's 457(b) Plan. **Please note that your investment provider may also require its own paperwork in addition to this form.** After this form has been received, your request will be reviewed and, if approved, forwarded to you or your Provider for their processing.

### Participant Information

|                                          |                             |
|------------------------------------------|-----------------------------|
| Full Name: (last, first, middle initial) |                             |
| Address: (street, city, state and zip)   |                             |
| Social Security Number:                  | Date of Birth: (MM/DD/YYYY) |
| Phone Number: (with area code)           | Email Address:              |
| Employer:                                |                             |

### Distributable Event

Select the corresponding qualifying event for the distribution or rollover below. If none of the reasons listed below apply, you may not be eligible for a distribution or rollover from your Plan. You may, however, be eligible for a distribution based on an unforeseeable emergency, if permitted by your employer's Plan. **Please contact AFPlanServ with any questions.**

- Termination of employment or retirement from Employer; **Date of termination/retirement:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Attainment of age 59 ½
- Death of Participant; **Must provide copy of the death certificate**
- Small account distribution; **If Plan permits and not to exceed \$7,000**
- Qualified Domestic Relations Order; **Provide a copy of the filed QDRO**
- Plan termination; **Provide written confirmation from Employer**
- Qualified Disaster Recovery Distribution; **Provide documentation supporting loss and location of loss, not to exceed \$22,000**
- Qualified Birth and Adoption Distribution; **Provide birth certificate or the signed Decree of Adoption**
- Domestic Abuse Survivor; **Provide one of the following:**
  - o A copy of the police report or Protective order from the court
  - o A copy of a formal complaint to the district's Title IX coordinator, other evidence from the court, administrative agency, school's Title IX coordinator, or attorney
  - o Other documents from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, or victim services provider

*If you have difficulty getting these documents or have concerns about safety, you can give an affidavit confirming you qualify for safe leave.*

### Source of Assets

Please indicate the name of the Provider from which you wish to take a distribution or rollover of funds.

|                                    |
|------------------------------------|
| Provider:                          |
| Account/Policy/Contract number(s): |

### Destination of Assets, If a Rollover

Please indicate the name of the Provider/Institution that will receive the rollover of assets from above.

|                                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Provider/Institution:                                                                                                                                                                                                              |
| Account Type: <input type="checkbox"/> 403(b) <input type="checkbox"/> 457(b) <input type="checkbox"/> 401(k) <input type="checkbox"/> 401(a) <input type="checkbox"/> Traditional IRA <input type="checkbox"/> Roth 403(b)/457(b) |
| Account/Policy/Contract number(s):                                                                                                                                                                                                 |

### Participant Acknowledgement

By signing this form, I certify that the information Additionally, I have provided is accurate. I have satisfied all of the requirements to request this transaction. I have verified that it is permissible under the terms of my 403(b) Plan and the terms of the annuity contract(s)/custodial account(s) indicated above. I understand and agree that the involvement of the third-party plan administrator in this transaction is limited to this authorization.

Participant or Benefeciary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|                                  |                             |
|----------------------------------|-----------------------------|
| <b>AFPlanServ Use Only</b>       |                             |
| AFPlanServ Authorized Signature: | Approval Date: (MM/DD/YYYY) |