DENBRIGHT DENTAL LABS 401(k) PLAN
APPLICATION FOR HARDSHIP DISTRIBUTION AND
PARTICIPANT HARDSHIP ELIGIBILITY SELF-CERTIFICATION FORM

Complete all sections and **PRINT clearly in Blue or Black ink.** Your signature is required in Part 6. If your home address is NOT a U.S. address, you must also complete a Form W-8BEN and return it with this form. Failure to attach Form W-8BEN, if required, will delay your payment.

Part 1 PARTICIPANT INFORMATION

Participant Name (Last, First, MI)			Social Security Number
Street Address			Date of Birth
City	State	Zip Code	Date of Hire
Daytime Phone Number	Email Address		Company Division or Location

Part 2 REQUEST FOR HARDSHIP DISTRIBUTION AND PARTICIPANT SELF-CERTIFICATION

I am applying for an in-service distribution from my plan account due to financial hardship. I confirm that this request satisfies the reason(s) indicated below and that I have and will retain the required documentation listed below in support of my distribution request.

The hardship amount I am requesting is $_____ (enter amount of immediate financial need).

Check one or more boxes as applicable & answer all corresponding questions for the box(es) checked regarding the hardship request:

☐ **PAYMENT FOR UNREIMBURSED MEDICAL EXPENSES** (described in Section 213(d) of the Internal Revenue Code) previously incurred or necessary to obtain medical care for myself, my spouse, my child(ren), my other dependents or my designated primary beneficiary as allowed under the terms of the Plan.

1. Who incurred/will incur the medical expenses (list name(s))?_____
2. What is the relationship to you, the plan participant (self, spouse, child/dependent, primary beneficiary under the Plan)?
3. What was the purpose of the medical care (not actual condition but category of expense, e.g., diagnosis, treatment, prevention, associated transportation, long-term care)?
4. What is the name and address of the service provider?_____
5. What amount of medical expenses were not covered by insurance? _____

Required documentation to be maintained by Participant: Bill with amount due, description of services rendered and insurance payments or an explanation of benefits that corresponds with the bill.

☐ **COSTS DIRECTLY RELATED TO PURCHASE OF MY PRINCIPAL RESIDENCE** (excluding mortgage payments).

1. Will this be your principal residence (yes or no)?_____
2. What is the address of the residence?_____
3. What is the purchase price of the principal residence?_____
4. What are the types of covered costs and expenses (e.g., down payment, closing costs, title fees)?_____
5. What is the name and address of the lender?_____
6. What is the date of the purchase or sale agreement?_____
7. What is the expected date of closing?_____

Required documentation to be maintained by Participant: Closing cost sheet, loan estimate or itemized fee statement with the property address.

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☐ **PAYMENT OF TUITION AND RELATED EDUCATIONAL FEES** including room and board expenses for the next twelve (12) months of post-secondary education for myself, my spouse, my child(ren), my other dependents or my designated primary beneficiary as allowed under the terms of the Plan.

1. Who are the educational payments for (list name(s))?_____
2. What is the relationship to you, the plan participant (self, spouse, child/dependent, primary beneficiary under the Plan)?
3. What is the name and address of the educational institution?_____
4. List the categories of educational payments involved (e.g., post-high school tuition, related fees, room and board):
5. What is the period covered by the educational payments (beginning/end dates of up to 12 months)?_____

Required documentation to be maintained by Participant: Bill with the student's name, amount due, charges/credits, what the school term charges are for and the school's name or letterhead indicated on the bill. If funds are for books, a "voided" receipt or shopping cart print out showing the cost of books.

☐ **PREVENTION OF EVICTION OF FORECLOSURE** from my principal residence.

1. Is this hardship related to your principal residence (yes or no)?_____
2. What is the address of the residence?_____
3. What is the type of event (foreclosure or eviction)?_____
4. What is the name and address of the party that issued the foreclosure or eviction notice?_____
5. What is the date of the notice of foreclosure or eviction?_____
6. What is the due date of the payment to avoid foreclosure or eviction?_____

Required documentation to be maintained by Participant: Notice from landlord or mortgage company indicating the property location, future eviction or foreclosure date and the amount due required avoiding eviction or foreclosure.

☐ **PAYMENT FOR BURIAL OR FUNERAL EXPENSES** for my deceased parent, spouse, child, dependent or my designated primary beneficiary as allowed under the terms of the Plan.

1. What is the name of the deceased?_____
2. What is the relationship of the deceased to you, the plan participant?_____
3. What is the date of death?_____
4. What is the name and address of the service provider (e.g., cemetery or funeral home)?_____

Required documentation to be maintained by Participant: An itemized/detailed bill from a funeral home, mortuary, crematorium and/or religious establishment with the amount due.

☐ **PAYMENT OF EXPENSES FOR THE REPAIR OF DAMAGE TO MY PRINCIPAL RESIDENCE** that qualify for a casualty loss deduction under Section 165 of the Internal Revenue Code.

1. Is this your principal residence (yes or no)?_____
2. What is the address of the residence that sustained damage?_____
3. What is the date of the loss and the cause of the casualty loss (e.g., fire, flooding or type of weather-related damage)?
4. What are the repairs and their date, and are they in process or completed? _____

Required documentation to be maintained by Participant: Estimate from a contractor of cost to repair damages due to casualty losses to principal residence, and a statement from insurance company indicating coverage or denial letter. If no homeowner's insurance, the estimate must state the exact cause of damage and that no insurance money will be received toward payment.

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☐ **PAYMENT OF EXPENSES AND LOSSES (INCLUDING LOSS OF INCOME) INCURRED AS A RESULT OF A DISASTER DECLARED BY THE FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA)** for myself, my spouse, my child(ren), my other dependents or my designated primary beneficiary as allowed under the terms of the Plan, provided that my principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster, and provided that I have not otherwise been reimbursed for such expenses and losses.

1. Please provide a general description of the expenses or losses, each of which must have occurred within the last twelve (12) months (e.g., food, shelter, essential personal items, fuel, moving/storage, restoration/cleaning):

   _____

   _____

   _____

2. Who are the expense or loss payments for (list name(s))?_____

   _____

3. What is the relationship to you, the plan participant (self, spouse, child/dependent, primary beneficiary under the Plan)?

   _____

4. Confirm you reside and/or work in an area designated by FEMA as a disaster area (complete one or both sections):

   ☐ My residence is in a FEMA designated disaster area:

   County: _____Date of Disaster: _____
   Address: _____

   ☐ My place of employment is in a FEMA designated disaster area:

   County: _____ Date of Disaster: _____
   Address: _____

5. Are you are requesting payment due to loss of income (yes or no)?_____
   IF YES, enter the loss of income start date_____; and
   the anticipated loss of income return date _____

Required documentation to be maintained by Participant: An itemized receipt or an unpaid invoice evidencing the expense(s), name of billing entity, itemization of the costs, total amount due (dated within 60 days as of the date of the request).

I understand that this Application for Hardship Distribution and Self-Certification must be completed and approved prior to the processing and receipt of the hardship distribution. I also understand that any distribution will only be made from that portion of my account which is vested and available for hardship distribution per the terms of the Plan, and that this amount cannot exceed my immediate and heavy financial need as indicated above.

If my application is approved, I understand that my plan account will be reduced by the amount I receive and that the distribution will be taxable to me in the year in which I receive it and it may also be subject to a 10% early distribution penalty.

I further understand that my hardship distribution may be increased (but cannot exceed the maximum amount available under the Plan) to include amounts necessary to pay federal and state taxes, as well as any applicable penalty, and that I may elect this by checking the box below:

☐ I wish to increase the amount of hardship distribution withdrawn from my account to include any federal and state tax withholding amounts per my elections in Parts 4 and 5 as well as any applicable tax penalty.

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Part 3 PAYMENT DIRECTION

I request a hardship distribution for the amount and reason(s) indicated in Part 2 above. Payment should be made as indicated below.
Check ONE box:

☐ Check payable to me at the address in Part 1

☐ Direct Deposit (you must complete the Direct Deposit Instructions below)

DIRECT DEPOSIT INSTRUCTIONS payable by WIRE or ACH*	
☐ Direct Deposit to my Checking account	☐ Direct Deposit to my Savings account
Financial Institution Name:	
ABA/Routing Number (9 digits):	
Account Number:	
Account Owner Name:	

*If the financial institution provided you with direct deposit instructions, also attach a copy of the instructions.

Part 4 FEDERAL INCOME TAX WITHHOLDING

Hardship distributions from your **pre-tax** account are subject to 10% withholding for federal income tax purposes.

Hardship distributions from your **Roth** account are subject to 10% withholding on earnings for federal income tax purposes only, if the account has not met the requirements for a "qualified distribution" under IRS rules.

You may elect to have an amount greater than 10% withheld for federal income tax purposes, or you may elect NOT to have withholding apply to your distribution. If you choose not to have federal income tax withheld, you are still liable for payment of any federal income tax on the taxable portion of your distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

I elect the following federal income tax withholding for my hardship distribution - **check ONE box:**

☐ Withhold 10%

☐ Withhold _____% (enter a whole % greater than 10%)

☐ No withholding

Part 5 STATE INCOME TAX WITHHOLDING *(If you reside in a state that does not have a state income tax, skip this Part)*

The taxable portion of your payment may also be subject to state income tax based on your state of residence. If state income taxes are not withheld from your payment, you are liable for any state income tax on the taxable portion of your payment. If you do not complete this Part by checking ONE box below, state income tax will only be withheld if required by the state at the time of the distribution and will be calculated per the state's statutory withholding rate. You will need to provide any *required* state withholding forms for your *election of withholding or election out of withholding*. For tax information pertaining to your resident state, contact your tax advisor or your state income tax department.

State of Residence: _____

☐ I elect out of mandatory state withholding. I reside in a state that generally requires state income tax to be withheld from the taxable portion of payments where federal income tax has been withheld, but allows me to opt out of such state withholding.

☐ I make a voluntary election to have the amount indicated below withheld for state income tax. I reside in a state that does not require state income tax to be withheld from the taxable portion of payments where federal income tax has been withheld, but allows me to request income taxes to be withheld.

$ _____ (must be in whole $) **OR** _____% (must be a whole %)

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Part 6 PARTICIPANT CERTIFICATION AND AUTHORIZATION (REQUIRED)

I understand and certify that:

- The distribution amount I have applied for is not greater than my immediate financial need that I indicated in Part 2 above
- I have obtained all distributions, other than hardship distributions, available under all plans of my employer
- I have insufficient cash or other liquid assets to satisfy my financial need at this time
- If this hardship request is resulting from a FEMA federally declared disaster, I reside and/or work in an area identified for individual assistance by FEMA and I have not otherwise been reimbursed (by my insurance, employer or FEMA) for my loss of income and other hardship expenses
- I understand that any misrepresentation or false statements may result in additional IRS tax and/or other penalties
- If I have not reached age 59½, this distribution is subject to an additional 10% nondeductible premature distribution penalty tax
- This distribution will be subject to an automatic 10% federal income tax withholding unless I elected otherwise in Part 4 above
- I am not able to roll over any amount I received as a hardship to an IRA or other qualified plan
- I must provide any additional information which the Plan Administrator may require to approve my request
- I agree to retain and provide all required source documents in support of my hardship at any time upon request

By signing this form, I certify to the Plan Administrator that the information I have provided regarding my need for a hardship distribution is true and accurate and, to the best of my knowledge, is sufficient to qualify as a hardship under the Plan, and I agree to hold the Plan, Plan Administrator and USI Consulting Group harmless for the accuracy of the information I have provided with regard to this hardship request.

Participant Signature (Handwritten signature preferred; Typed signatures are not valid and will not be accepted)	Date

If you have any questions, please call the USICG Participant Service Center at (866) 305-8846, Plan Code **713**

After completing this request, return it for processing using one of the options below:

Mail: Denbright Dental Labs - Attn: Griselda Castellanos – 1108 Investment Blvd. El Dorado Hills, CA 95762 Email:

griselda@denbright.com

Please make a copy of this form for your records

EMPLOYER AUTHORIZATION AND APPROVAL OF HARDSHIP DISTRIBUTION– NOT to be completed by Participant		
I have reviewed this application for hardship distribution to confirm the participant completed all required information and I certify that I have no actual knowledge to the contrary.		
Plan Administrator Signature	PRINT Plan Administrator Name	Date

USI CONSULTING GROUP OFFICE USE ONLY

Vested %	**d/f**	**M* a/c**

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