Denbright Dental Labs 401(k) Plan
IN-SERVICE DISTRIBUTION REQUEST FORM

Complete all sections and **PRINT clearly in Blue or Black ink.** Your signature is required in Part 7. You must read the Tax Notice regarding plan payments prior to completing this form.

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 IMPORTANT INFORMATION REGARDING PLAN PAYMENTS – READ PRIOR TO COMPLETING THIS FORM

I understand the following:

1. If my home address is NOT a U.S. address, I must also complete a Form W-8BEN and return it with my completed In-Service Distribution Request form. Failure to attach Form W-8BEN will delay my payment.

2. MINIMUM NOTICE PERIOD: For at least 30 days after I receive this form and the Tax Notice regarding plan payments, I have the right to consider my decision whether to consent to a distribution of my vested account balance and whether to elect a direct rollover of any portion of my eligible rollover distribution. If I sign and return this form less than 30 days after I receive the form and Tax Notice, the receipt of my signed form is my affirmative waiver of any unexpired portion of the minimum 30 day period and my affirmative election of a distribution or a direct rollover.

3. If I elect to have the Plan Administrator directly roll over my Plan payment to an Individual Retirement Account (IRA) or another employer sponsored eligible retirement plan, I must arrange to have that IRA or other plan accept the payment and I must furnish the Plan Administrator of this Plan with all information necessary to make my Plan payment payable to the other program.

4. I should confirm the accounts (i.e., money sources) in which I have a balance in the plan prior to completing Part 3 so that I can indicate the specific account(s) from which I am requesting payment and confirm that I have sufficient funds available in those accounts.

5. The Plan may charge a fee for the processing of my distribution. A separate fee may apply for the Roth and non-Roth portions of my payment.

6. Part 4 of this form has two sections – one for non-Roth balances and one for Roth balances. I may need to complete one or both sections, depending on my specific account, to provide directions for my payment.

Part 3 DISTRIBUTION OF PLAN ACCOUNTS

Per the terms of the Plan, I request a distribution from my plan account as indicated in this Part 3 of the form **(*check the account(s) from which you are requesting a distribution and complete all applicable items*).**

I understand that the distribution will be based on the value of my account(s) as of the date on which the distribution is processed. I further understand that if the account(s) checked below from which I request a distribution do not have sufficient funds to fulfill my request, but I have other accounts eligible for distribution, any remaining portion of my distribution will be withdrawn pro-rata from my other eligible accounts in order to fulfill the total amount of my distribution request.

☐ **Rollover Account Distribution:** I may request a distribution of all or a portion of my rollover account (money previously rolled into this plan) at any time.

I request a distribution of *(check ONE):*

☐ $ _____ from my rollover account

☐ My entire rollover account

☐ **Vested Employer Account Distribution:** I may request a distribution of all or a portion of my fully vested employer accounts available for withdrawal at any time after I attain age 59 ½.

I request a distribution of *(check ONE)*:

☐ $ _____ from my vested employer account

☐ My entire vested employer account

☐ **Pre-tax Deferral Account Distribution:** I may request a distribution of all or a portion of my pre-tax deferral account at any time after I attain age 59 ½.

I request a distribution of *(check ONE):*

☐ $ _____ from my pre-tax deferral account

☐ My entire pre-tax deferral account

☐ **Roth Deferral Account Distribution:** I may request a distribution of all or a portion of my Roth deferral account at any time after I attain age 59½ provided my account has met the requirements for a "qualified distribution" under IRS rules.

I request a distribution of *(check ONE)*:

☐ $ _____ from my Roth deferral account

☐ My entire Roth deferral account

Part 4 PAYMENT DIRECTION FOR NON-ROTH BALANCES – Complete only if all or a portion of your payment IS NOT from a Roth account
(use the next page to request payment of a Roth account balance – your selections on this page apply only to a non-Roth balance)

SECTION A: I request the following option *(check ONE box and complete any applicable information):*

☐ **Payment directly to my USI Annuity** {**NOTE**: To select an annuity option call 866-551-2525 or visit financialendurance.org}

☐ **Payment directly to a rollover IRA or eligible employer plan – check ONE option:**

☐ Send check (you must complete Section B) OR ☐ Wire (you must complete Section C)

☐ **Payment directly to me *(subject to mandatory 20% federal income tax withholding)* – check ONE option:**

☐ Send check payable to me at the address in Part 1 OR ☐ Direct Deposit or ACH (you must complete Section D)

☐ **Payment of a portion $_____directly to me. Check ONE option for this portion of the payment.**

☐ Send check payable to me at the address in Part 1 OR ☐ Direct Deposit or ACH (you must complete Section D)

AND the remaining balance paid directly to a rollover IRA or eligible employer plan. Also check ONE option:

☐ Send check (you must complete Section B) OR ☐ Wire (you must complete Section C)

SECTION B: CHECK INSTRUCTIONS <u>for Payment to a Rollover Institution</u> for Non-Roth Balances. Complete to request a rollover check payable to another employer plan or IRA - provide instruction below as directed by the financial institution to indicate how the rollover check should be made payable. The rollover check will be mailed to you. You may not cash the check and must deliver it to the rollover plan or IRA for deposit into your account.
Make check payable to: (Name of Financial Institution)
For Benefit Of (FBO): (Participant name)
Plan name and/or Account # (if applicable)

SECTION C: WIRE INSTRUCTIONS <u>for Payment to a Rollover Institution</u> for Non-Roth Balances (Information in this section pertains to the rollover institution ONLY; do not enter your name or personal banking info. here)**		
Financial Institution Name:		
ABA/Routing Number (9 digits):	Account Number:	
Account Owner Name:	For Further Credit:	
Financial Institution City:	State:	Zip Code:

SECTION D: DIRECT DEPOSIT OR ACH INSTRUCTIONS <u>for Payment Directly to Me</u> for Non-Roth Balances**	
☐ 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 instructions for deposit by Wire or ACH, attach a copy of the instructions.

Part 4 (continued) PAYMENT DIRECTION FOR ROTH BALANCES – Complete only if all or a portion of your payment IS from a Roth account*

SECTION A: I request the following option *(check ONE box and complete any applicable information):*

☐ **Payment directly to a rollover IRA or eligible employer plan – check ONE option:**

☐ Send check (you must complete Section B) OR ☐ Wire (you must complete Section C)

☐ **Payment directly to me – check ONE option:**

☐ Send check payable to me at the address in Part 1 OR ☐ Direct Deposit or ACH (you must complete Section D)

☐ **Payment of a portion $_____directly to me. Check ONE option for this portion of the payment.**

☐ Send check payable to me at the address in Part 1 OR ☐ Direct Deposit or ACH (you must complete Section D)

AND the remaining balance paid directly to a rollover IRA or eligible employer plan. Also check ONE option:

☐ Send check (you must complete Section B) OR ☐ Wire (you must complete Section C)

SECTION B: CHECK INSTRUCTIONS for Payment to a Rollover Institution for Roth Balances. Complete to request a rollover check payable to another eligible employer plan or Roth IRA - provide instruction below as directed by the financial institution to indicate how the rollover check should be made payable. The rollover check will be mailed to you. You may not cash the check and must deliver it to the rollover plan or Roth IRA for deposit into your account.
Make check payable to: (Name of Financial Institution)
For Benefit Of (FBO): (Participant name)
Plan name and/or Account # (if applicable)

SECTION C: WIRE INSTRUCTIONS for Payment to a Rollover Institution for Roth Balances (Information in this section pertains to the rollover institution ONLY; do not enter your name or personal banking info. here)**		
Financial Institution Name:		
ABA/Routing Number (9 digits):	Account Number:	
Account Owner Name:	For Further Credit:	
Financial Institution City:	State:	Zip Code:

SECTION D: DIRECT DEPOSIT OR ACH INSTRUCTIONS for Payment Directly to Me for Roth Balances**	
☐ 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:	

*Payments made directly to you may be subject to mandatory 20% federal income tax withholding if the distribution is not a "Qualified" distribution.
**If the financial institution provided you with instructions for deposit by Wire or ACH, attach a copy of the instructions.

Part 5 FEDERAL INCOME TAX WITHHOLDING ***(If you elected a direct rollover & your payment is not subject to withholding, skip to Part 7)***

Federal law requires that 20% of any taxable payment made directly to you be withheld for income tax purposes. You may choose to have an amount greater than 20% withheld by indicating your withholding election below (leave blank unless you want more than 20% withheld).

☐ I elect to have _____% withheld from my payment for federal income tax withholding (enter a whole % greater than 20%)

Part 6 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 %)

Part 7 PARTICIPANT AUTHORIZATION (REQUIRED)

I certify that:

(1) I have read the Tax Notice regarding plan payments prior to completing this form;

(2) I understand the information contained in Part 2, including the minimum notice period;

(3) I understand the terms and conditions of my choices indicated above; and

(4) the information contained herein is accurate and complete to the best of my knowledge.

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 – NOT to be completed by Participant		
Plan Administrator Signature	PRINT Plan Administrator Name	Date

USI CONSULTING GROUP OFFICE USE ONLY		
Vested %	d/f	M* a/c