Denbright Dental Labs 401(k) Plan
PAYMENT REQUEST FORM

Complete all sections and **PRINT clearly in Blue or Black ink.** Your signature is required in Part 6. 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	Date of Hire
City	State	Zip Code	Date Employment Ended	
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 I am the beneficiary of a participant in the Plan requesting a payment due to the death of the participant, I must submit a Death Benefit form instead of this form.

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

3. Distributions cannot be processed until all contributions and loan repayments (if any) are received by the Plan following the last payroll period of my employment.

4. MINIMUM NOTICE PERIOD: For at least 30 days after I receive this Payment Request 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.

5. If the value of my Plan benefit **excluding my rollover account balance exceeds $7,000,** I am not required to receive a distribution of my Plan benefits until I reach my required distribution date under the Plan.

6. 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.

7. If I am required to receive a Required Minimum Distribution (RMD), my payment will consist of two components: (1) my RMD and (2) the remainder of my account balance. In addition to this form, I must submit a Request for Required Minimum Distribution Form for that portion of my payment.

8. 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.

9. Part 3 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 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)

Check ONE then go to Section A: ☐ **Distribute my entire vested account OR** ☐ **Distribute a portion $_____ of my vested account**

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)

☐ **Installment Payments $_____ per installment until my account is fully distributed – check ONE option:**

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

Frequency (check ONE box): ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Note: If your plan assesses distribution fees, they will apply to each installment.

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

Check ONE then go to Section A: ☐ **Distribute my entire Roth account OR** ☐ **Distribute a portion $_____ of my 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)

☐ **Installment Payments $_____ per installment until my account is fully distributed – check ONE option:**

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

Frequency (check ONE box): ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Note: If your plan assesses distribution fees, they will apply to each installment

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 4 FEDERAL INCOME TAX WITHHOLDING ***(If you elected a direct rollover & your payment is not subject to withholding, skip to Part 6)***

For distributions that are eligible for rollover to another employer plan or IRA, federal law requires that 20% of any taxable lump sum 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 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 %)

Part 6 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

Qualifying Event (check ONE box): ☐ Termination ☐ Disability ☐ Retirement ☐ QDRO (Contact USICG)

Date of Event: _____

Participant's Final Payroll Date: _____

Plan Administrator Signature	PRINT Plan Administrator Name	Date

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Vested %	d/f	M* a/c