DENBRIGHT DENTAL LABS 401(k) PLAN
QUALIFIED BIRTH OR ADOPTION DISTRIBUTION 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 will delay your payment.

Part 1 PARTICIPANT INFORMATION				
Participant Name (Last, First, MI)			Social Security Number	
Street Address			Date of Birth	Date of Hire
City	State	Zip Code	Marital Status ❑ Married ❑ Not Married	
Daytime Phone Number	Email Address		Company Division or Location	

Part 2 INFORMATION ABOUT QUALIFIED BIRTH OR ADOPTION DISTRIBUTIONS

A qualified birth or adoption distribution is an in-service withdrawal from your retirement plan account for expenses related to a birth or adoption that occurred on or after **January 1, 2022**. No documentation is required to be attached to this form but should be retained in your files and/or submitted upon request.

An eligible adoptee is any person (other than a child of your spouse who is not also your child) who has not attained age 18 or who is physically or mentally incapable of self-support. The distribution must be made within one year following the birth or legal adoption.

The aggregate amount that you can receive per child or adoptee cannot exceed $5,000 across all of your retirement plan accounts.

Qualified birth or adoption distributions from the Plan may only be taken from your vested account balance.

A qualified birth or adoption distribution may be repaid to a qualified retirement plan as a rollover contribution. However, repayments made after the extended due date of your income tax return for the year of distribution may require you to file an amended return*.

Part 3 AMOUNT OF QUALIFIED BIRTH OR ADOPTION DISTRIBUTION AND PAYMENT DIRECTION

I elect to withdraw $_____ (enter amount of distribution here – may not exceed the lesser of $5,000 or your vested account balance).

I understand that my distribution will be made from that portion of my account which is vested, and that my Plan account will be reduced by the amount I receive. **The Plan may charge a fee for the processing of my distribution**.

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**	
☐ 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:	

*You may wish to consult a tax advisor

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

Part 4 FEDERAL INCOME TAX WITHHOLDING

Qualified birth or adoption distributions are subject to 10% federal income tax withholding but are not subject to a 10% early withdrawal penalty. Unless you elect otherwise, 10% will be automatically withheld for income tax purposes. You may want to consult your tax advisor for further information regarding this distribution.

Please check ONE box below regarding your federal income tax withholding election:

☐ I elect to have 10% withheld

☐ I elect to have a different amount withheld:

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

☐ I elect **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)*

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 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 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:

- The birth or adoption distribution requested herein satisfies the requirements of Internal Revenue Code Section 72(t)(2)(H) and I understand that to the extent this distribution does not qualify under section 72(t)(2)(H), then I shall be liable for any applicable tax penalties
- I understand that federal law mandates that the total withdrawals from all qualified retirement plans for each qualified birth or adoption cannot exceed $5,000
- I have and will retain appropriate documentation in support of my distribution 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 BIRTH OR ADOPTION DISTRIBUTION– NOT to be completed by Participant		
Plan Administrator Signature	PRINT Plan Administrator Name	Date

USI CONSULTING GROUP OFFICE USE ONLY	
Vested Balance	**d/f**