CORONAVIRUS-RELATED DISTRIBUTION REQUEST FORM

Section 1: PARTICIPANT INFORMATION

Plan Name

Last Name First Name MI

Employee ID Number

Address - Number and Street

City State Zip

Date of Birth: _____/_____/_____

Date of Hire: _____/_____/_____

Current Marital Status: ☐Single ☐Married

( )

Phone

Email Address

Section 2: SELF-CERTIFICATION

By signing below, I certify that this coronavirus-related distribution is being requested due to one of the following reasons:

- I, my spouse, or my dependent have been diagnosed with SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention (including a test authorized under the Federal Food, Drug and Cosmetic Act)
- I have experienced adverse financial consequences because myself, my spouse or member of my household experienced the following due to COVID-19:
    - Being quarantined, furloughed, laid off, or having work hours reduced
    - Being unable to work due to lack of childcare
    - Closing or reducing hours of a business that I/they own or operate
    - Reduction in pay or self-employment income
    - Having a job offer rescinded or start date for a job delayed
- I have met other other factors as determined by the Secretary of the Treasury

Section 3: PAYMENT AMOUNT AND TAXATION

I wish to withdraw $_____ as a coronavirus-related distribution.

- The amount above cannot exceed the lesser of: (i) the balance of your vested Account; or (ii) $100,000 (determined by aggregating all coronavirus-related distributions from any plan maintained by the employer (and any member of any controlled group which includes the employer)).
- **A flat 10% withholding rate will be applied to the taxable amount unless you choose not to have federal income tax withheld on the attached Form W-4P.**
- **The distribution request must be processed prior to December 31, 2020.**
- You may wish to consult with a professional tax advisor for information about special tax treatment related to this distribution and the ability to contribute this distribution back into a retirement plan or IRA.
- Unless otherwise requested, your distribution fees will be withheld from your plan account balance.

Section 4: DISTRIBUTION ELECTION

Unless otherwise requested, distribution will be paid to you in the form of a check and mailed to the address provided in Section 1.

If you would like Electronic Funds Transfer for your distribution, please complete the information below *(contact Plan Administrator for any terms or conditions)*:

Bank name_____

ABA Routing # (nine digits) _____

Account # _____

Type of account (checking or savings) _____

Section 5: SIGNATURES

I hereby certify that the information above has been examined by me and that the information contained on this form is, to the best of my knowledge, accurate. I agree to provide any additional information that may be necessary to process my request.

Dated this _____ day of _____, 2020.

_____
Signature of Participant

_____
Print Name of Participant

As Plan Administrator, I hereby authorize the above withdrawal.

Dated this _____ day of _____, 2020.

_____
Signature of Plan Administrator

_____
Print Name & Title of Plan Administrator

Completed forms can be sent to TRA by fax at 800.459.5815, via secure email at processing@tra401k.com, or mailed to 600 S. Nicolet Rd., Appleton, WI 54914-8233

SPOUSE'S CONSENT TO DISTRIBUTION
REQUIRED IF APPLICABLE

I. NOTICE OF RIGHT TO SURVIVING SPOUSE'S BENEFIT AND IMPACT OF DISTRIBUTION

Under this Plan, the surviving spouse of a deceased, married Participant is generally entitled to a legally-mandated "surviving spouse's benefit". A married Participant cannot take this distribution unless his or her spouse consents because it would reduce the benefit payable on account of the Participant's death. This consent form is not required if the participant is not married at the time the distribution is made.

II. SPOUSE'S CONSENT TO DISTRIBUTION

I hereby consent to my spouse's obtaining a distribution in the amount set for the above. I further acknowledge my understanding that: (1) the effect of my consent is to forego benefits to which I may otherwise be entitled upon my spouse's death, and (2) my consent is irrevocable.

Dated at _____, this ____ day of _____, 2020.
[City, State]

_____
Signature of Participant's Spouse

_____
Name of Participant's Spouse
(print or type)

Witnessed by:
Notary Public, State of _____
My Commission (is permanent/expires)

_____ _____
Authorized Representative of Plan Administrator

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