ELECTION TO REFUND DEFERRALS

Plan Name: _____

Participant Name: _____
Print or Type Complete Legal Name – First, MI, Last

Social Security Number: _____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

As an eligible employee in the above-named plan, I hereby elect not to have any further deferrals automatically taken from my compensation and I elect to have the Plan distribute to me all of my prior automatic deferrals and allocable earnings or losses on the deferrals.

I understand that I must make this election within 90 days of the first automatic deferral being taken from my compensation. I understand that I will pay income tax on the distributed amount, but I will not be subject to the 10% premature distribution penalty tax, even if I receive the distribution prior to age 59 1/2.

I acknowledge that I will forfeit any matching contributions on the distributed amounts.

_____ _____
Participant Signature Date

_____ _____
Plan Administrator Signature Date