# South Carolina State Firefighters' Association
# Length of Service Awards Program (LOSAP)

## Application for Benefit Distribution
## (Retirement, Disability or Death)

### Personal Data:

| | | |
|---|---|---|
| FIRST NAME | M.I. | LAST NAME |
| DATE OF BIRTH (MM/DD/YY) | | SOCIAL SECURITY NUMBER (LAST 4 DIGITS) |
| DEPARTMENT | | |
| ADDRESS (STREET, APT#) | | ADDRESS (CITY, STATE AND ZIP CODE) |
| DATE OF HIRE | | DATE OF PARTICIPATION |
| DATE OF TERMINATION | | VESTING % |
| NAME OF BENEFICIARY (IF DEATH BENEFIT) | | RELATIONSHIP TO DEPARTMENT MEMBER |
| BENEFICIARY SOCIAL SECURITY NUMBER (FULL SSN) | | BENEFICIARY DATE OF BIRTH (MM/DD/YYYY) |
| BENEFICIARY ADDRESS (STREET, APT#) | | BENEFICIARY ADDRESS (CITY, STATE AND ZIP CODE) |

### Request Reason (please select one):

- ◯ Normal Retirement (NRA) (please check one):
  - ◯ I have attained Normal Retirement Age
  - ◯ I have satisfied the 20-year service requirement for NRA
- ◯ Disability *(You must qualify under the Plan Definition of "disability" as defined in the plan document.)*
- ◯ Death

### Distribution Timing (please select one):

- ◯ Pay Immediately*

  **If you select this option, distributions are processed monthly and must be received at least 2 weeks prior to the cut-off dates. You will not share in the earnings allocation of the current valuation period. (Valuation periods end each June 30 and December 31.)*

- ◯ Pay after next valuation date
- ◯ Defer until Normal Retirement Age

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### Distribution Method (please select one):

☐ **Lump Sum Cash Payment**. I understand the payment amount will be equal to my vested account balance, based on the vesting % indicated above.

### Participant Certification:

I understand that:

- This payment will be reportable as taxable income in the year of receipt.
- I am electing to receive a full distribution of my vested account balance.
- A distribution processing fee will be assessed against my account balance when payment occurs.
- In making this election, I hereby consent to the receipt of this amount in full satisfaction of my benefits under the Plan.

**Participant's Signature**_____ **Date**_____

### Plan Sponsor Authorization for Payment of Benefits:

- The above determination of benefits has been approved.
- I/We certify that the participant has satisfied the plan's requirements to take a distribution from the plan.
- Authorization is hereby given to make the payment to the above-named former participant based on the information shown above.

**Authorized Signature**_____ **Date**_____

**Authorized Signature**_____ **Date**_____

**Authorized Signature**_____ **Date**_____