South Carolina State Firefighters' Association Retirement Plan and Trust

Application for In-Service Distribution

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
YEARS OF SERVICE		VESTING %

Request Reason:

☐ In-Service Distribution

- *This is an Irrevocable election by an ACTIVE employee who is at Retirement Age or has 20 years of service. Payment is a single lump sum of all or a portion of the vested account balance which must be rolled to a qualified plan (see below). Cash payments are **not** allowed.*

Distribution Amount (please select one):

◯ Please distribute $_____of my vested account balance (see distribution timing below).

◯ Please distribute my entire vested account balance (see distribution timing below).

Distribution Timing (please select one):

◯ Pay Immediately – Plan distributions are processed monthly and must be received at least 2 weeks prior to the cut-off dates. If you select this option, 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.

Rollover Election (please select one):

I hereby instruct the plan to roll the Distribution Amount elected above directly to one of the following:

◯ A 401(a) qualified plan, including the State Retirement Plan
◯ An eligible 403(b) annuity contract
◯ An eligible governmental 457(b) plan

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Application for In-Service Distribution (continued)

Rollover Instructions:

PLAN NAME		
CHECK PAYABLE TO		
ATTENTION OF	ACCOUNT NUMBER	
MAILING ADDRESS		
CITY	STATE	ZIP CODE

Participant Certification:

By completing this application:

- I confirm that I have not received any prior in-service distributions from the plan.
- I understand that this is a one-time irrevocable request.
- I understand no further distributions from the plan will be available to me until I have terminated employment.
- I acknowledge that a processing fee will be assessed against my account balance when payment occurs.

Participant's Signature_____ **Date**_____

Plan Sponsor Authorization for Payment of In-Service Distribution:

Based on the provisions of the Plan document:

- I/We certify that the participant satisfies the requirements to be eligible to take an in-service distribution from the plan.
- Authorization is hereby given to make the payment to the participant based on the information shown above.

Authorized Signature_____ **Date**_____

Authorized Signature_____ **Date**_____

Authorized Signature_____ **Date**_____