



DISTRIBUTION FORM

Company Name

Please be advised, this notice only applies to plans that have elected the Automatic Rollover provisions of section 401(a)(31)(B) of the Internal Revenue Code. This notice supplements any distribution forms provided to you. As explained in the forms, you may elect to receive a distribution or have the distribution rolled over to an IRA. Due to a change in the law, if you fail to elect either of these options within 30 days of receiving this form, the Plan is required to automatically make a direct rollover of your balance to an IRA with Mid Atlantic Trust Company. This notice supersedes any inconsistent statements in the distribution forms regarding payment to you in a lump sum in the event you fail to elect either of these options. The trustee or issuer of the IRA will impose fees for maintaining the IRA. These fees will be paid from the IRA. However, you may transfer the IRA funds at any time to another IRA or retirement plan that will accept such amounts.

PARTICIPANT INFORMATION

Social Security Number First Name MI Last Name Address City State Zip Code + 4 Work Phone Number Home Phone Number Date of Birth

WITHDRAWAL AMOUNT

Maximum Amount Or Specific Dollar Amount \$

Notice: A \$55 check processing fee will be deducted.

WITHDRAWAL INSTRUCTIONS

100% Cash, 100% Rollover, Split Distribution. 20% Federal Taxes will be deducted. Specific Dollar Amount \$ OR % (This is for the cash part of the split distribution). Please review the Special Tax Notice and complete the Rollover Instructions for the balance of your withdrawal.

ROLLOVER INSTRUCTIONS

Qualified Retirement Plan IRA Name of Financial Institution/Trustee Account Number Address Line 1 City State Zip Code + 4

PARTICIPANT/SPOUSE AUTHORIZATION

I am legally not married or I am married and my Spouse's consent appears below. Signature of Spouse (If applicable) Date Signature of Participant (Required) Date Signature of Witness (Required) Date

PLAN ADMINISTRATOR USE ONLY

Reason: Separation of Service Disability Retirement Date of Hire Date of Termination Plan Year-to-Date

I authorize the above transaction and acknowledge that the information provided herein is complete and accurate.

Signature of Plan Authorized Signer (Required) Date Printed Name of Plan Authorized Signer

Please fax completed form to 601-914-2329 or mail to Dyatech, 805 South Wheatley Suite 600, Ridgeland, MS 39157. Incomplete forms will be returned to Plan Administrator for completion and discarded after 30 days of receipt if completed form is not received. For assistance with forms, please contact our Customer Service Dept. at 866-651-4222, ext. 400.

Please fax completed form to 601-914-2329 or mail to Dyatech, 805 South Wheatley Suite 600, Ridgeland, MS 39157.