

PLAN DISTRIBUTION REQUEST UPON SEVERANCE OF EMPLOYMENT – Page 1 of 2

PART I – PARTICIPANT INFORMATION

Plan Name:			
Employer/Plan Sponsor Name:		Division/Department:	
Participant Name:		Social Security No.:	
Participant Address:		Telephone No.: ()	
City:	State:	Zip:	
Date of Birth:		Date of Hire:	
Reason for Severance (Check one): <input type="checkbox"/> Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Disability (Attach proof of Disability) <input type="checkbox"/> Death Benefit			
<input type="checkbox"/> Participant's Death (Attach copy of Participant's Death Certificate)		Employment Severance Date:	

If the distribution is a Death Benefit, the Participant's Spouse and/or Non-Spouse Beneficiary also must complete below .

Spouse/Beneficiary Name:		Spouse/Beneficiary Date of Birth:	
Relationship to Participant:		Spouse/Beneficiary Social Security No.:	

PART II- PARTICIPANT ELECTION OF BENEFIT OPTION

I request the distribution of my vested benefit as follows (Please check box A, B or C below):

A. <input type="checkbox"/> Convert to Nationwide Insurance Company IRA Rollover Note: Non-spouse beneficiaries may <u>not</u> elect this option.	Nationwide IRA Account No.:		
B. <input type="checkbox"/> Direct Rollover to my IRA or Other Qualified Retirement Plan (Please complete below): Note: Non-spouse beneficiaries may <u>not</u> elect this option.			
Name of Institution (IRA or Qualified Plan):			
Mailing Address:	City:	State:	Zip:
IRA Account (Required for IRA Rollovers): You must establish an IRA account with a financial institution prior to electing this benefit distribution option.		IRA Account No.:	
C. <input type="checkbox"/> Lump Sum Cash Payment: I understand that 20% of my total cash distribution <u>must</u> be automatically withheld to pay Federal Taxes.			
OPTIONAL: <input type="checkbox"/> I would like to receive the following portion in cash and the balance of my vested distribution (minimum \$500) directly rolled over in accordance with my rollover instructions as indicated above).			\$
OPTIONAL: <input type="checkbox"/> Please also withhold an additional amount for State Taxes at the rate percentage I indicate here:			%

PART III- PARTICIPANT WAIVER AND AUTHORIZATION

I have received and read the enclosed "Special Tax Notice Regarding Plan Payments." I understand the income tax information on distributions from qualified plans as explained in the Notice and further understand that neither a rollover or cash payment can be made until the minimum waiting period of at least 30 days after receipt of this Notice has elapsed. If I do not wish to wait the 30 days for my distribution, I may make an affirmative election to waive the waiting period, whereby my distribution will be processed in accordance with my benefit option elections made in Part II above as soon as administratively feasible after it is received by the Employer/Plan Sponsor. I hereby waive the 30-day Waiting Period.

Participant/Beneficiary Signature: _____ Date: _____

I understand the options offered to me and that by my signature below, I hereby authorize the distribution of the vested value of my plan account in accordance with my election of the benefit options indicated in Part II above. I understand that (1) these elections may be changed at any time by notifying the Employer/Plan Sponsor prior to the distribution (subject to spousal consent, if applicable), and (2) if I am entitled to an additional contribution, the vested value may be distributed at a later date, and such additional distribution may require the completion of additional forms.

Participant/Beneficiary Signature: _____ Date: _____

NOTE: You must return your completed Distribution Request Form to your Employer/Plan Sponsor for final authorization.

PART IV – EMPLOYER/PLAN SPONSOR INFORMATION AND AUTHORIZATION

The Employer/Plan Sponsor must complete the following before this request can be processed.

Check Hours Worked from the start of the Current Plan Year to Participant's last day of employment: <input type="checkbox"/> 0-500 <input type="checkbox"/> 501-999 <input type="checkbox"/> 1000 Hours or more	
Current Plan Year Compensation (as defined by the plan document) up to Participant's last day of employment:	\$
Date the Employer/Plan Sponsor provided the "Special Tax Notice" to the Participant:	/ /
The Participant's final payroll contribution will be for the payroll period ending (please indicate last payroll date):	/ /
Employer/Plan Sponsor Authorized Signature: _____	Date: _____

IMPORTANT NOTE: This Distribution Request will not be processed unless it is completed fully and accurately, has been approved by the Employer/Plan Sponsor, and contains all the required signatures for authorization.

PLAN DISTRIBUTION REQUEST UPON SEVERANCE OF EMPLOYMENT – Page 2 of 2

PARTICIPANT INFORMATION (Please copy from Page 1)

Plan Name:

Employer/Plan Sponsor Name::

Division/Department:

Participant Name:

Social Security No.:

PART V – PARTICIPANT WAIVER OF MINIMUM SURVIVOR ANNUITY

A. Waiver of Minimum Survivor Benefit (if Election is offered by the Plan).

1. I have been advised in non-technical terms of the available forms of benefits under the captioned Plan(s), their relative financial effects, and the circumstances in which benefits will be provided. I have also carefully considered my eligibility to receive my benefits in the Qualified Joint-and-Survivor Annuity form or Qualified Pre-Retirement Survivor Annuity form, or both (hereinafter severally and jointly referred to as the "Minimum Survivor Benefit Form").
2. I hereby certify that I do not wish to receive my Plan benefits in the Minimum Survivor Benefit Form. I (and if I am currently married, my spouse) hereby waive any and all rights which might become available under said Minimum Survivor Benefit Form. I (and if I am married, my spouse) hereby release the Plan, Employer, Plan Sponsor and Plan Trustees from any liability resulting from waiver of the above-mentioned forms of benefit.
3. I hereby consent to the distribution of my Account (as defined in paragraph "B.1" hereto) in a form other than the Minimum Survivor Benefit Form (regardless of the amount to be so distributed) at such time or times as I direct the Trustees.

B. Benefit Form.

1. Election. In the event I or my beneficiaries become entitled to Plan benefit payments at any time, I elect that such benefits shall not be paid in the form of a Qualified Joint-and-Survivor Annuity or Qualified Pre-Retirement Survivor Annuity. Instead, such benefits shall be based upon my vested Allocated Share in any defined contribution plan in which I am a Participant or upon the lump sum actuarial equivalent of my vested Accrued Benefit in any defined benefit plan in which I am a Participant (hereinafter referred to as my "Account") and shall be payable in any one or a combination of the Optional Forms of Benefit as permitted by the Plan (other than the Minimum Survivor Benefit Form) and as I (or in case of my death, my beneficiary) shall designate (or shall have designated) in writing filed with the Trustees (or if no valid designation shall have been or can then be made, then payment shall be made as provided in the Plan).
2. Limitation. Anything to the contrary notwithstanding, the period for the payment of benefits to me or my Beneficiaries shall not exceed such period as may be required by the Internal Revenue Code as amended and Regulations and Rulings thereunder.

C. 1. Effectiveness of Election. This waiver and election shall be effective immediately, or as of the earliest date that such waiver and election may be made under the terms of the Plan(s). I (or in the event of my death, my beneficiary) shall have the continuing right (without the consent of any person) to revise, amend, modify or revoke any or all of the provisions hereof by a later dated instrument in writing. This instrument shall be effective only if delivered to the Trustee prior to my death. Any designation pursuant hereto shall be subject to all of the terms and conditions of the Plan.

2. Notification Requirement. If, prior to the commencement of benefit payments, my marital status changes from that set forth in subparagraph 3, below, I will immediately inform the Plan Representative or Trustee, in writing.
3. Marital Status. I hereby certify that I am: Married. My spouse's name is: _____ Not Married.

Participant Signature: _____ Date: _____

D. 1. Trustee's Acknowledgment: This Election was received by Trustees of the captioned Plan, consented and agreed to on the date below.

Employer/Plan Sponsor Authorized Signature: _____ Date: _____

PART VI – SPOUSAL CONSENT OF ANNUITY WAIVER (FOR MARRIED PARTICIPANTS)

I am currently married to the Participant named on this form. I understand that unless I waive my rights by signing in the space provided below, benefits under the Plan(s) will be paid in the form of a Qualified Joint and Survivor Annuity and/or a Qualified Pre-Retirement Survivor Annuity. I have been provided with an explanation of (a) the terms and conditions of such Minimum Survivor Benefit Forms, (b) the right to waive such benefit forms and (c) the effect of any such waiver. I understand that (i) I am waiving the rights described above, (ii) my spouse's waiver and election is not valid unless I consent to it, and (iii) the effect of my consent to this waiver and election may be to forfeit benefits I would be entitled to receive upon my spouse's death. I further understand that I have the right to limit consent to a specific beneficiary and a specific optional form of benefit, and I voluntarily elect to relinquish both of such rights.

I hereby consent (i) to my spouse's election out of the Minimum Survivor Benefit Form and (ii) to the distribution of my spouse's Account in a form other than the Minimum Survivor Benefit Form (regardless of the amount to be so distributed) at such time or times as my spouse shall direct the Trustees and (iii) to the distribution of my spouse's Account in such form or forms as my spouse shall elect. I also consent to any further beneficiary designations or revisions or changes therein or in the form of benefit payment or in the benefit commencement date that may be made from and after the date hereof by my spouse or any beneficiary designated pursuant hereto, and I waive any right to object or to require my consent thereto. I understand that I have the right to limit consent to a specific beneficiary and a specific optional form of benefit, where applicable, but I voluntarily elect to relinquish both of such rights. This waiver and consent is irrevocable and I retain no right to amend, modify or revoke all or any of the provisions hereof.

Spouse Signature: _____ Date: _____

Witnessed by Employer/Plan Sponsor or Notary Public: _____ Date: _____

IMPORTANT NOTE: This Distribution Request will not be processed unless it is completed fully and accurately, has been approved by the Employer/Plan Sponsor, and contains all the required signatures for authorization.