# Medical City Dallas Management, Ltd. 401(k) Profit Sharing Plan
# IN-SERVICE DISTRIBUTION REQUEST

**This form to be completed while you continue to be employed at Medical City Dallas Management, LTD and would like to receive a distribution of your available accounts. If you have terminated from this employer and want a distribution, you must complete a separate form.**

As a Participant in **Medical City Dallas Management, Ltd. 401(k) Profit Sharing Plan,** I hereby request payment of my benefit as provided below:

1. Name: _____

   Street Address: _____

   City, State, Zip: _____

   Social Security No.: _____

   Daytime Phone No.(_____)_____ Date of Birth: _____

2. Amount of payment **$_____**

3. Form of payment (choose only one option)

   [ ] Lump Sum – **($60.00 processing fee)** Withholding tax in the amount of 20% will be deducted from payment.

   [ ] Direct Rollover to IRA – **($60.00 processing fee)** Rollover check must be made payable to the IRA. Please indicate below whom to make check payable:

   To:_____Acct#_____

   Address:_____

   _____

   [ ] Direct Rollover to IRA with CecilCo Provided Products **(No processing Fee if account balance if at least $5,000.00).** Either contact **Casey Waits** at CecilCo 1-800-795-401k OR enter your contact information below:

   Day Time Phone_____ Evening Phone_____

**02/09**

## Medical City Dallas Management, Ltd. 401(k) Profit Sharing Plan
# IN-SERVICE DISTRIBUTION REQUEST (cont.)

**YOU MUST COMPLETE SECTION 1, SECTION 2, <u>OR</u> SECTION 3 BELOW. SECTION 4 <u>MUST</u> BE SIGNED AND NOTARIZED.**

**1.** **Spouse's Consent:** I hereby approve of, and consent to, the payment option elected by my spouse as provided above.

_____
Signature of Spouse

**2.** **Certification if no Spouse:** I hereby certify that I am not currently married and that there are no Plan benefits payable to a former spouse under a qualified domestic relations order.

_____
Signature of Participant

**3.** **Account Balance less than $5,000**: I hereby certify that I am married and my account balance is less than $5,000.

_____
Signature of Participant

**4.** **Please distribute my account balance according to the directions in this form. In consideration of all plan participants, I further agree to return to the plan any funds that may be inadvertently overpaid to me due to clerical error. (Must be signed before distribution check can be released):**

Printed Name:
_____SSN#:_____

_____
Signature of Participant

**This request will not be processed without a notary endorsement.**

**NOTARY SEAL:**
Signed and Sworn before me this _____day of _____,
20_____.

_____
Signature of Notary Public

**02/09**

# PARTICIPANT'S WAIVER OF 30-DAY NOTICE REQUIREMENT UNDER SECTION 402(f)

**This form must be signed or your distribution cannot be issued for 30 days after receipt of these forms.**

I wish to have my distribution from the **Medical City Dallas Management, Ltd. 401(k) Profit Sharing Plan** made as soon as possible in accordance with the In-Service Distribution form that I returned to the plan administrator. Therefore, I hereby waive the 30-day time period otherwise required between the date the "IRC Section 402(f) Notice" was provided to me and the date that my election regarding my distribution is implemented.

In connection with this waiver, I hereby confirm the following:

1. that I acknowledge receipt of a written "IRC Section 402(f) Notice," setting forth the various distribution options available to me;

2. that I understand that I am entitled to a reasonable period of not less than 30 days from the date the notice was provided to me in which to decide whether to make or not make a direct rollover of my distribution; and,

3. that, notwithstanding my waiver, I continue to have the opportunity within the 30-day period to reconsider my decision of whether or not to elect a direct rollover until my election is actually implemented.

Printed Name: _____ SSN#: _____

Signature:_____ Date: _____

**02/09**