



Medical City Dallas

## 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 the **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 Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

Daytime Phone No. (\_\_\_\_) \_\_\_\_\_

2. **AMOUNT OF PAYMENT \$** \_\_\_\_\_ OR Maximum Available [ ]

3. **FORM OF PAYMENT (choose only one option)**

[ ] Lump Sum – **(\$85.00 processing fee)** Withholding tax in the amount of 20% will be deducted from payment.

[ ] Direct Rollover to IRA – **(\$85.00 processing fee)** Check must be made payable to the IRA. Please indicate below whom to make check payable:

Payable To: \_\_\_\_\_ Acct# \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

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THIS SECTION **MUST** BE SIGNED AND NOTARIZED.

5. 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):

Print Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**Please Note: We do not accept Electronic Signatures**

## NOTARY SEAL:

Notary Name: \_\_\_\_\_

Signed and Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

County of Signing: \_\_\_\_\_ Notary for State of: \_\_\_\_\_

Signature of Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_

Notary Address \_\_\_\_\_

Notary Phone Number \_\_\_\_\_ Notary Fax Number \_\_\_\_\_ Notary email address \_\_\_\_\_

Name(s) of People Notarized \* \_\_\_\_\_  
(Participant and spouse, if any) \_\_\_\_\_

Did signor(s) provide a photo ID issued by a government entity? No  Yes  Type of ID: \_\_\_\_\_  
(driver license, passport, military ID, state ID, company ID, tribal card)

Please disclose any relationship you may have with the above signor(s). If none, write n/a. \_\_\_\_\_

**\*Notaries please remember to reflect if signor is utilizing a power of attorney.**

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## 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: **Please Note: We do not accept Electronic Signatures:**

Date: \_\_\_\_\_