Medical City Dallas Management, LTD 401(k) Profit Sharing Plan

APPLICATION FOR BENEFITS

Please allow up to 4 weeks for processing

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 No.: _____________________ Email: _______________________________________

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

Last Pay Period: _______________________

Distribution may not be processed prior to termination date and only after final 401(k) contribution has been posted to your investment account. ***Your check will be mailed directly to you from Nationwide in Columbus, Ohio.***

2. Reason for Payment

[ ] Termination of Employment: Date of Termination ______/_____/_____

[ ] Retirement [ ] Disability [ ] Qualified Domestic Relations Order

3. Form of Payment (choose only one option below): Please note: Any additional deposits to your account after this distribution will require another distribution to be processed per these instructions and **will be charged an $85.00 processing fee**.

[ ] Lump Sum – Federal withholding tax in the amount of 20% will be deducted from payment.

[ ] Direct Rollover – Rollover check must be made payable to the IRA or retirement plan. Please indicate below to whom to make rollover check payable:

Payable to: ____ Acct# _____________________

Address: ____

____

Any unpaid loan balance at the time of distribution will be deemed a distribution and included as taxable income on Form 1099R for the year in which the distribution is taken.

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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):

Printed Name: ______________________________________ SSN: __________________________

____ __________________________

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

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

Names of People Notarized * ____

____

____

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 benefits election form(s) 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) Special Tax 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) Special Tax 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: ______________________

Please Note: We do not accept Electronic Signatures

NOTICE TO TERMINATED PARTICIPANT

It is your responsibility to notify the Employer or the Plan Administrator of any change in address. Otherwise, we will be unable to locate you.

The Employer's name and address is:

Medical City Dallas Management, LTD
7777 Forest Lane, Bldg C #840
Dallas, Texas 75230
(972) 566-4625

OR

CecilCo
14881 Quorum Drive, Suite 340
Dallas, TX 75254
(972) 239-4059, (800) 795-401k
participantservice@cecilco.com