



401(a) Defined Contribution Plan BENEFICIARY DISTRIBUTION REQUEST

INSTRUCTIONS

This form can only be used for 401(a) Defined Contribution plans

- Please be sure to complete and sign all applicable sections. If you have any questions, please contact Florida Municipal Pension trust Fund (FMPTF) by calling toll free 1-800-342-8112 or email us at fmptf@flcities.com.
- Please attach a *certified copy* of the Participant's death certificate.
- A \$75.00 fee will be charged for initial set-up of a distribution. Recurring payments will be charged an additional \$5 per payment.
- Additional information is available at www.flretirement.com.

SECTION 1 – PARTICIPANT INFORMATION

Name of Deceased (print full name)

Social Security Number or Taxpayer Identifying Number

Date of Death

Date of Birth

Employer/Plan Name

Plan Number

SECTION 2 – BENEFICIARY INFORMATION

Beneficiary's Name (print full name)

Social Security Number or Taxpayer Identifying Number

Home Address

Daytime Telephone Number (optional)

City State Zip Code

Date of Birth

Spouse Yes No

US citizen Yes No

Primary Beneficiary Contingent Beneficiary

If contingent beneficiary is checked, please attach a *certified copy* of the death certificate for the primary beneficiary.

Participant Name: _____

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SECTION 3 – PAYOUT OPTIONS

Complete whichever *Option applies*: *Minimum Distribution Rules apply*

Lump Sum Distribution

Entire Plan Account balance

- OR -

Available to Spouse Beneficiary Only— Direct Rollover

A direct rollover occurs when your distribution is paid to an eligible retirement plan (including an IRA) that has agreed to accept this rollover. **The receiving institution must be indicated below** and must be an insurance company, bank, trust company, IRS-approved custodian, or employer plan trustee.

If this direct rollover is to be made during or after the year in which the participant would have turned 70½, you cannot roll over the portion of the distribution that is a required minimum distribution (RMD).

A. Select a direct rollover option:

- Direct Rollover of Entire Plan Account Balance
- Direct Rollover of Partial Plan Account Balance of \$ _____, and a Lump Sum Distribution of the remaining account balance
- Partial Lump Sum Distribution of \$ _____, and a Direct Rollover of the remaining Plan Account balance.

B. Receiving Institution (Entity as listed above)

FBO (Beneficiary's Name)

Important: The rollover check will be mailed directly to the address specified in Section 1 of this form. You are responsible to promptly invest this check into your new Plan or IRA. (Do not deposit directly into your personal savings account.) When you send it, remember to include your new account number; doing so will help your new insurer, custodian, or trustee process the check to your account.*

Participant Name: _____

SECTION 4 – AUTHORIZATION FOR ELECTRONIC DIRECT DEPOSIT

- Direct deposit is available for monthly, quarterly, semi-annual, and annual distributions, and lump sum distributions.
- Direct Deposit is not available for Rollover Requests.

Complete only one option: I request that my distributions be directly deposited to the following account:

Checking Account: *Attach a pre-printed void check below (starter checks not accepted)*

Bank/Credit Union Name

Telephone Number

|: ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ |:

First nine digits only of ABA Number (required)

(Appears at bottom of check between markings indicated above)

Account Number

VOID CHECK

Savings Account:

Attach a savings account advice slip below. (if available)

Bank/Credit Union Name

Telephone Number

|: ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ |:

First nine digits only of ABA Number (required)

(Contact your bank for ABA Number)

Account Number

Savings Account Advice Slip

I authorize the FMPTF to initiate automatic deposits to my account indicated above with the financial institution named above. This authority will remain in effect until I have given FMPTF written notice that I have stopped it. I understand that I must give FMPTF enough advance notice to allow FMPTF reasonable time to act on my instructions. If an incorrect amount is entered into my account, I authorize FMPTF to direct my bank to make the appropriate credit or debit adjustment. The FMPTF may end this service at any time without notice.

Beneficiary's Signature

Date

Participant Name: _____

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SECTION 5 – BENEFICIARY CERTIFICATION

I request a distribution on account of the death of the participant. I have received the *Special Tax Notice Regarding Plan Payments* concerning the federal income tax treatment of this distribution. I certify that everything I completed on this form is true, correct, and complete. I certify, under penalties of perjury, that my Social Security Number or other Taxpayer Identifying Number shown on this form is correct. I certify that I am **not** domiciled in or a resident of any place other than the address shown on this form. I understand that I may be subject to civil and criminal penalties and punishment for any knowingly false statement on this form. If the Plan, an insurer, or a custodian pays or fails to pay any benefit in reliance on my false statement, I will be liable for the damages, including (but not limited to) investigation expenses, legal fees and costs.

Beneficiary's Signature

Date

SUBMITTING THIS FORM:



You must submit this form to the participant's former Employer/Human Resources Department (not the FMPTF) for the Employer to complete the next section. The FMPTF will NOT process this request unless the Employer has completed and signed the next section.

SECTION 6 – EMPLOYER'S INSTRUCTION AND APPROVAL

Complete Participant's Vested Percentage for *employer contributions* up to and including 100%.

Employer Matching Contributions _____%

Employer Non-Matching Contributions _____%

Participant's Date of Hire (*required*)

Participant's Date of Severance (if applicable)

Please designate the percentage that this beneficiary is entitled to receive from the deceased Participant's entire Plan account. Before completing this section, you should check the Participant's latest beneficiary designation in your Plan's records.
_____ % (up to and including 100% of total Plan account)

I certify the accuracy of the Vested Percentage(s) shown above and if a total distribution was specified, instruct the transfer of any non-vested account balance to the Plan's Forfeiture Account. I approve the distribution requested by this form and, if applicable, the direct rollover.

Authorized Signature on behalf of the Employer

Date

Name and Title (print full name)

Please submit completed forms to:
Florida Municipal Pension Trust Fund
P.O. BOX 1757
TALLAHASSEE, FL 32302

For Internal Use Only

SECTION 7 – PLAN ADMINISTRATOR'S INSTRUCTION AND APPROVAL

Florida League of Cities, Inc.
Name of Plan Administrator Organization

Beneficiary Percentage

Authorized Signature on behalf of FMPTF

Date

Processed By: _____

Date

Plan Administrator MUST keep original