SOUTH CAROLINA STATE FIREFIGHTERS ASSOCIATION
RETIREMENT PLAN AND TRUST

TERMINATION/IN SERVICE DISTRIBUTION FORM

DEPARTMENT: _____

NAME: _____

SOCIAL SECURITY NUMBER: _____

Termination from Department: _____ **or In-Service**: _____

If termination, Please provide the date: _____

REASON FOR FORM:
_____In-Service ____Terminated ____Normal Retirement ____Disability ____Death*

I, _____, as Chief of _____Fire Dept
(Print Name)
Certify that the above date and reason for this form is correct or that the individual electing a One Time In-Service Distribution has met the criteria.

_____ _____
(Chief's Signature) **(Date)**

PARTICIPATION INFORMATION:

Address _____

_____ Phone: _____

Date of Birth _____ Date of Employment _____

Vested % _____ Email Address _____

Unless you have reached one of the following criteria to receive a pay-out or rollover from your 1% fund:

20 yrs. of Service (with that dept.), Retirement Age (of that dept.), Disability or Death*

A Paid Firefighter can rollover to another Qualified Plan*. ****For Beneficiary Only*

METHOD OF DISTRIBUTION (CHECK ONE)

_____ LUMP SUM TO PARTICIPANT OR BENEFICIARY (Taxable Distribution)

- _____ 20 Years of Service (with that dept)
- _____ Retirement Age (of that dept)
- _____ Disability
- _____ Death

_____ ROLLOVER DISTRIBUTION

_____ IN-SERVICE ROLLOVER

- _____ 20 Years of Service (with that dept)
- _____ Retirement Age (of that dept)

TIMING OF DISTRIBUTION (CHECK ONE)

_____ PAY IMMEDIATELY

- I understand I will not share in the earnings allocation from the prior valuation date. ***Valuation dates are June 30th and December 31st of each plan year.***

_____ PAY AFTER THE NEXT VALUATION DATE

____ DEFER UNTIL NORMAL RETIREMENT AGE

SPECIAL TAX NOTICE

I, _____, have received and reviewed the Special Tax Notice Regarding Plan Payments.

I realize a 20% Federal Income Tax Withholding will be deducted on all distributions paid directly to a participant or beneficiary from an eligible retirement plan. There will be no State Income Tax deducted. There is a $40.00/1099 & Check Processing Fee which will be deducted from the gross amount.

***BENEFICIARY INFORMATION: (In case of death of the participant only)**

NAME: _____

ADDRESS: _____

_____

SOCIAL SECURITY NUMBER: _____

SIGNATURES

PARTICIPANT/BENEFICIARY: _____

SPOUSE: _____

MANAGING COMMITTEE MEMBERS:

_____	_____
NAME	SIGNATURE
_____	_____
NAME	SIGNATURE
_____	_____
NAME	SIGNATURE

DATE: _____