

**DESERT HOSPITAL RETIREMENT PROTECTION PLAN  
REQUEST FOR LUMP SUM PAYOUT**

Print Name: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Hire by Hospital: \_\_\_\_\_

Separation date Hospital: \_\_\_\_\_

Check if this Lump Sum Payout is for a ( ) Rollover or ( ) Cash Out

**Statement by Participant – Request for Lump Sum Payout:**

I revoke and cancel any prior request for election of optional forms of retirement benefit which I may have made, and I accept the Lump Sum benefits elected option in full settlement and complete satisfaction of my rights and benefits under the Plan and contract.

I further state that as of the date for signing this form, I am:

Check One: ( ) Single ( ) Married -- Please complete Spouse's Consent section below.

\_\_\_\_\_  
Participant's Signature Date

**SPOUSE'S CONSENT**

I understand the effect of this benefit election and give my consent to my spouse's election of a Lump Sum payment.

\_\_\_\_\_  
Spouse's Signature Date

**PLAN ADMINISTRATION**

\_\_\_\_\_  
Signature of Plan's Administrator Date

\_\_\_\_\_  
Printed name of Plan's Administrator

**NOTARY (REQUIRED)**

State of California  
County of \_\_\_\_\_

On \_\_\_\_\_ before me, \_\_\_\_\_, personally appeared \_\_\_\_\_ who proved to me on the basis of satisfactory evidence to be the person(s) whose name (s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the forgoing paragraph is true and correct.

\_\_\_\_\_  
Notary Signature

Notary Seal

## PARTICIPANT ELECTION FORM

Desert Hospital Retirement Protection Plan  
Trust Name

Trust # 6746128600

### MAILING INSTRUCTIONS

SECTION I

(Participant Name)

(Participant SSN)

(Beneficiary or Alternate Payee Name)

(Beneficiary/Alternate Payee SSN)

(Complete only if payment is due to death or QDRO.)

(Mailing Address)

(The address to which payments to me and IRS Form 1099R should be sent.)  
(If foreign address, complete "Certificate of Foreign Status" or "IRS Form W9", whichever is applicable)

**Note:** Direct rollover checks will be mailed to the participant's mailing address as indicated above.

- \_\_\_ Mail check directly to the participant/beneficiary/alternate payee.
- \_\_\_ If receiving stock, deliver stock through DTC using receiving institution's DTC #
- \_\_\_ Wire Transfer to the Institution/Trustee or Custodian (Attach Wire Instructions.)
- \_\_\_ ACH to the Institution/Trustee or Custodian (Attach ACH Instructions.)

**For Wire/ACH Transfers:**

(circle one)

\_\_\_\_\_  
(ABA/Transit Number)

Bank A/C # \_\_\_\_\_

Bank Name \_\_\_\_\_

*Please Note: If a wire is requested, please attach a check made payable to U.S. Bank, N.A. in the amount of \$15.00 for each wire requested to cover the additional wire fee. If a check is not attached, a check will be issued to the Financial Institution and mailed to your address instead of a wire. (Fee does not apply to ACH transfers)*

### DISTRIBUTION ELECTION: (CHECK APPLICABLE ELECTION)

You may wish to consult your tax advisor on your particular tax consequences prior to making an election. Once the distribution is made, **it is irrevocable.** *Please Note:* If you do not specify an option or return this form, 20% Federal Income tax will be withheld (unless total taxable amount is under \$200) and a check for the remainder will be issued directly to you. The income tax withheld is non-refundable, however, you may declare it on your IRS Form 1040 at the end of the year. Any after-tax employee contributions will automatically be paid by check to the participant unless otherwise directed.

SECTION II

**DIRECT TRANSFER TO IRA (only available to participant, surviving spouse or former spouse as a result of a QDRO.)**

Attach any forms for transfer or re-registration instructions required by the receiving institution.

\_\_\_ Check here and attach additional instructions if multiple transfers are requested.

\_\_\_ Check here to distribute total account balance **OR**

\$ \_\_\_\_\_ Amount of total taxable portion to be transferred (must be more than \$500 if transferring less than 100% of amount eligible for rollover).

\_\_\_\_\_  
(Payee Line of Check/Your Rollover Institution)

\_\_\_\_\_  
(Mailing Address of Participant)

(IRA Account #) \_\_\_\_\_

**CAPACITY OF PAYEE:**     Trustee     Custodian

**Special Instructions:** \_\_\_\_\_

SECTION IV

**ISSUE CHECK** - If payable to the participant/surviving or former spouse subject to 20% federal withholding

**FEDERAL TAX WITHHOLDING:** Nonspouse beneficiaries must attach separate tax election form.

**STATE TAX WITHHOLDING:** State tax will be withheld according to the rules and rates in effect at the time of distribution. If you reside in a state that requires mandatory withholding, an election to not have taxes withheld will be disregarded and your distribution will be subject to the statutory minimum required withholding.

**A** I want \_\_\_\_\_ State Income Tax withheld at the applicable rate from the taxable portion of  
(Name of State)  
my distribution.

**B** I do not want to have State Income Tax withheld from the taxable portion of my distribution.

I understand the terms and conditions relating to the payment of taxable benefits from the plan as explained in the Special Tax Notice provided by my employer.

In addition, I understand that it is my responsibility to obtain all necessary information from the IRA institution or New Employer's Qualified Plan for the direct rollover. I certify that (i) this information is correct and (ii) the IRA or Employer's Qualified Plan will accept a direct rollover whether in cash or in kind (i.e., property other than cash). I acknowledge that I have been advised to consult a tax advisor regarding any tax consequences this distribution may have.

I hereby authorize payment of my vested account balance as indicated above. By signing this form, I am accepting responsibility for assuring the funds are received by the Institution/Trustee or Custodian specified above.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Dated)