

**Charlotte Behavioral Health Care, Inc. Retirement Plan
Death Benefit Distribution Form**

Please Print. Complete all applicable areas and attach a Death Certificate

Part I. Deceased Employee Information:

Name: _____ Social Security #: ____-____-____
Address: _____ Date of Birth: __/__/____
City: _____ State: ____ ZIP Code: _____
Date of Death: __/__/____

Status of Deceased:

- | | |
|---|---|
| <input type="checkbox"/> Employee | <input type="checkbox"/> Former Employee |
| <input type="checkbox"/> Retiree – Receiving Benefits | <input type="checkbox"/> Required Minimum Distribution Status |
| <input type="checkbox"/> Qualified Military Service | |

Part II. Beneficiary: (Please complete a separate Form for each Beneficiary.)

Name: _____ Date of Birth: __/__/____
Address: _____ Tax ID #: _____
City: _____ State: ____ ZIP Code: _____
Status: Surviving Spouse Date of Marriage: __/__/____
 Dependent/Minor Non-Spouse Beneficiary

Part III. Pre-Retirement Death Payment: (Complete this section if the Plan provides for a pre-retirement death benefit or permits the payment of the present value of the deceased Employee's vested interest in the Plan.)

- I hereby elect to receive a Lump Sum Payment in :
Cash Amount \$ _____ Direct Rollover Amount \$ _____

Part IV. Post-Retirement Death Payment. (Complete this section if at time of Death, Deceased Employee as eligible to receive a benefit from the Plan.)

- I hereby elect to receive my survivor benefit from Deceased Employee's annuity
 Immediately.
- I hereby elect to defer payment of this benefit until __/__/____
Note: Under the 5-year Rule benefit may be delayed until the fifth (5th) anniversary of the Deceased Employee's Death.

Part V. Death While in Required Minimum Distribution Status

I hereby elect to receive a Lump Sum Payment:

Cash Amount \$ _____ Direct Rollover Amount \$ _____

As surviving spouse or beneficiary I hereby elect to receive:

- Payments based on Required Minimum Distribution (RMD) term elected before the Deceased Employee's death.
- Recalculate based on the Beneficiaries' Life Expectancy

Method of Payment: Check ACH Express Delivery Electronic Fund / Wire Transfer

If ACH, Electronic Fund Transfer/Wirer Transfer to a designated account, please complete and attach a voided check or deposit slip:

Checking Account Saving Account

ABA-Routing # _____ Account # _____

Wire Transfer Routing # _____ Account # _____

Name of Financial Institution: _____

Address: _____

City: _____ State _____ ZIP Code _____

Express Delivery: I elect to have my payment delivered by Express Mail. I agree to pay the non-refundable delivery fee and understand that Express Mail terms.

Part VI. Transfer Instruction: Traditional IRA Inherited IRA Roth IRA

Qualified Plan (available for Surviving Spouse) Inherited IRA or Inherited Roth IRA (available for Non-Spouse Beneficiary)

Name of Plan or IRA:

_____ Plan or IRA Name and Account Number

Financial Institution: _____

Trustee/Custodian:

Address: _____

City: _____ State _____ ZIP Code _____

Part VII. Minor Legal Representation: Parent Legal Guardian

Name: _____

Address: _____

City: _____ State _____ ZIP Code _____

Part VIII. Taxation of Distribution: You can find more details on these requirements in the Section 402(f) Special Tax Notice. In general any distributions that you receive from an annuity, pension or retirement plan may be taxable as ordinary income and if you have not reached age 59-1/2, you may be subject to a 10% "premature distributions" penalty tax. For any distributions made to an address outside of the United States, a mandatory 30% withholding rate will apply, unless a completed IRS Form W-8BEN is submitted to the Plan Administrator.

Unless you elect one of the Direct Rollover options, 20% of this amount will be withheld for federal income tax.

Part IX. Required Signature: I hereby request a distribution from the Plan and acknowledge receipt of the Special Tax Notice. I certify that all information provide is true and correct.

Beneficiary Signature

__/__/____
Date

Minor Representative Signature

__/__/____
Date

Part X. Plan Administrator Certification: I hereby confirm receipt of this distribution form and a Death Certificate for the Participant. I hereby certify that payment is being made according to the attached Beneficiary Designation Form or pursuant to the terms of the Plan.

Plan Administrator Signature

__/__/____
Date