

Last Name

First Name

M.I.

U.S. Social Security Number

Number

D

Signatures and Consent (Signatures must be on the lines provided.)**Participant/Beneficiary Consent** (Please sign on the 'Participant/Beneficiary Signature' line below.)

This loan offset must be for the entire outstanding loan balance indicated on this form. If I have multiple loans and I have not indicated a loan number, all loans will be offset. I may be required to complete a new form or provide additional or proper information before the loan offset can be processed, in the event that any section of this form is incomplete or inaccurate. Any subsequent payments received on the loan number(s) indicated on this form will be refunded. An appropriate tax reporting form will be issued for the year in which the Loan Offset occurred.

I understand that if I have selected Disability as the loan offset reason, I must obtain either:

1. My physician's signature in 'Physician's Information and Certification of Disability' section, Or:
2. My Plan Administrator's certification. The certification must include ALL of the following: A) a check mark in the box provided; B) the date of my disability on the line provided; and C) the signature and date of my Plan Administrator in 'Authorized Plan Administrator Signature' section.

My signature acknowledges that I have read and understand this entire form and the possible tax consequences of this request and affirm that all information that I have provided is true and correct. Where I deem appropriate, I will seek a consultation with my tax advisor.

If I selected non-resident alien or other above, I must complete the 'Non-Resident Alien or Other Certification' section on this form. I may call 1-800-TAX-FORM (829-3676) or visit irs.gov for further information.

Under penalty of perjury, I certify that the U.S. Social Security number or U.S. Taxpayer Identification number I have provided in Section A is correct. I am a U.S. person if I marked the U.S. Citizen or U.S. Resident Alien box in Section A of this form.

Any person who presents false or fraudulent information is subject to criminal and civil penalties.

Participant/Beneficiary Signature _____ **Date (Required)** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Physician's Information and Certification of Disability (Please sign on the 'Physician's Signature' line below.)

Physician's Name _____

Name of Practice _____

Physician's Mailing Address
(_____) _____Physician's City/State/Zip Code
(_____) _____

Physician's Phone Number _____

Physician's Fax Number _____

Section §72(m)(7) of the Internal Revenue Code provides that a person is disabled "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration." Federal Treasury regulations provide that the "substantial gainful activity" to which §72(m)(7) refers is "the activity or a comparable activity in which the individual customarily engaged prior to the arising of the disability or prior to retirement if the individual was retired at the time the disability arose."

I, _____, under penalty of perjury, hereby certify that _____ (Participant's printed name)

is my patient who became totally and permanently disabled on _____ / _____ / _____ and has met and continues to meet the IRC §72(m)(7) definition of disability. (Date - mm/dd/yyyy)

Physician's Signature _____ **Date (Required)** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Authorized Plan Administrator Signature (Please sign on the 'Authorized Plan Administrator Signature' line below.)

The information provided by the participant/beneficiary is correct. This loan offset is in compliance with the Plan provisions. Process the loan offset for the reason described in this form.

I certify that the Participant met the disability requirements under the Plan document and is eligible to take this withdrawal.

I certify that the Participant's disability meets the IRC §72(m)(7) definition of disability and the date of their disability is _____ / _____ / _____. (mm/dd/yyyy)

I represent that I am an authorized signer on behalf of the above-named plan and have an authority to instruct Service Provider to process this form.

Authorized Plan Administrator Signature _____ **Date (Required)** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Print Full Name _____

Last Name

First Name

M.I.

U.S. Social Security Number

E Mailing Instructions				
After all signatures have been obtained, this form can be				
Uploaded Electronically: Login to account at empowermyretirement.com Click on Upload Documents to submit	OR	Sent Regular Mail to: Empower PO Box 173764 Denver, CO 80217-3764	OR	Sent Express Mail to: Empower 8515 E. Orchard Road Greenwood Village, CO 80111
We will not accept hand delivered forms at Express Mail addresses.				

Securities, when presented, are offered and/or distributed by Empower Financial Services, Inc., Member FINRA/SIPC. EFSI is an affiliate of Empower Retirement, LLC; Empower Funds, Inc.; and registered investment adviser Empower Advisory Group, LLC. This material is for informational purposes only and is not intended to provide investment, legal or tax recommendations or advice.