

HARDSHIP WITHDRAWAL REQUEST FORM

**PLAN NAME: Sheet Metal Workers' Union Local No. 33
Profit Sharing Annuity Plan**

PLAN NUMBER: SF 51696

I. PARTICIPANT INFORMATION

Name: _____ Social Security # _____
Last First MI

Address:

Street	City	State
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II. WITHDRAWAL REQUEST *(check one box in both sections A and B)*

A. I understand that the amount of my withdrawal must be necessary to satisfy an immediate and heavy financial need and that the amount of the withdrawal cannot exceed the amount necessary to meet that need. I represent that my need cannot be satisfied with other resources reasonably available to me, including the following:

- Reimbursement or compensation by insurance or otherwise
- Reasonable liquidation of my other assets (but only to the extent the liquidation of my assets would not in itself cause an immediate and heavy financial need). For these purposes I understand that my assets include those of my spouse and minor children that are reasonably available to me.
- Other distributions or nontaxable loans from any other plan maintained by any employer.
- Borrowing from commercial sources on reasonable commercial terms.

I also understand that my withdrawal will be paid on a pro-rata basis from all funds in which I am invested in the Plan.

☐ I request a withdrawal in the amount of \$ _____ Net Gross Available.
Enter amount requested

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B. My withdrawal is requested for the following reason:

- ☐ Expenses for (or necessary to obtain) medical care that would be deductible as medical expenses under the tax code; **(Please attach supporting documentation such as a recent bill from medical provider for balance due. EOBs are not sufficient documentation)**
- ☐ Costs directly related to the purchase of a principal residence for me (excluding mortgage payments) **(Please attach supporting documentation such as copy of purchase agreement);**
- ☐ Payments of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for myself, or my spouse, children or dependents **(Please attach supporting documentation such as copy of tuition bill for upcoming 12 months – amounts already paid for schooling do not qualify for hardship distribution);**
- ☐ Payments necessary to prevent the eviction of me and my family from my principal residence or foreclosure on the mortgage on that residence; **(Please attach supporting documentation such as eviction notice, foreclosure notice, or mortgage bill more than a month past due)**
- ☐ Payments for burial or funeral expenses for the my deceased parent, spouse, children or dependents; or **(Please attach supporting documentation such as funeral bill)**
- ☐ Expenses for the repair of uninsured damage to my principal residence that would qualify for the casualty deduction under the tax code **(Please attach supporting documentation such as repair bills)**
- ☐ Payment of self-pay rates directly to the Participant's applicable Union Health Plan in order to maintain health insurance coverage for you or your family. **(Please attach self-pay notification and sign authorization form set forth below in Section VII of the application)**
- ☐ Other immediate and heavy financial need such as amounts necessary to prevent loss of utility service on your principal residence, amounts for the repair of a vehicle necessary for work, amounts necessary to prevent the repossession of a vehicle necessary for work, home repairs necessary for occupancy of principal residence, or past due credit card statements that you are unable to pay as a result of a reduction in your income. **(Please attach supporting documentation such as utility shutoff notices, utility bills more than one month past due, repair bills/repossession notices/bills more than one month passed due for a vehicle necessary for transportation to and from work, or passed due credit card bills and associated documentation showing reduction in income)**

III. DISTRIBUTION METHOD - applies to the portion of your withdrawal made from your account in the Plan as well as any other portion of your withdrawal that you do not choose to roll over.

Distributions may not be directly rolled over when withdrawn due to hardship. Any portion of your distribution that is eligible to be directly rolled over to an IRA or a qualified retirement plan and is not directly rolled over, will automatically be subject to 10% withholding for Federal Income Tax purposes. For more information regarding the tax consequences of your distribution, please read the Special Tax Notice.

Please indicate your election by choosing one of the following:

A) Direct Payment to You – Your distribution will be made payable and sent directly to you. Indicate the method of payment below:

- ☐ Cash - Shares or other interests in any fund in the Plan from which your withdrawal is paid will be sold/redeemed and a check will be issued to you for the proceeds of the sale/redemption.

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IV. FEDERAL TAX WITHHOLDING ELECTION

This election applies only to the portion of your withdrawal made from your elective deferral account in the Plan.

Under the provisions of the Internal Revenue Code, the taxable portion of your distribution paid from your elective deferral account is subject to Federal Income Tax withholding unless you elect not to have withholding apply. IF YOU DO NOT MAKE AN ELECTION BY THE DATE YOUR DISTRIBUTION IS SCHEDULED TO OCCUR, FEDERAL INCOME TAX WILL BE WITHHELD AT A RATE OF 10% FROM THE TAXABLE PORTION OF YOUR DISTRIBUTION. If you elect not to have withholding apply, or if you do not have enough Federal Income Tax withheld from your distribution, you may be responsible for payment of estimated tax. You may be subject to tax penalties if your payments of estimated tax and withholding are not adequate. You should consider discussing this election with your tax advisor.

_____ **Yes, withhold tax**

_____ **No, do not withhold tax**

Complete this section if you checked yes above and you want a rate of Federal Income Tax withholding other than 10%:

Withhold Federal Income Tax at a rate of _____% or in the amount of \$ _____.

Note: Some states require tax withholding. If you reside in one of these states, state taxes may be withheld as well.

☐ **Additional or Voluntary Withholding :** I want \$ _____ (enter whole dollar amount) withheld from my payment for state income tax in addition to any required withholding.

V. SIGNATURE

I hereby certify that the information specified above has been examined by me and that the information contained on this form is, to the best of knowledge, true, accurate and complete.

I also certify that I have received and read the Special Tax Notice. I understand that I have the right to review this notice for at least thirty (30) days before deciding whether I want to directly roll over the portion of my withdrawal eligible to be rolled over or have the entire withdrawal paid directly to me. I further understand that, by executing and returning this withdrawal form in less than 30 days, I have waived my right to the 30-day waiting period.

Participant Signature

Date

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VI. SPOUSAL CONSENT - complete either Sections A and B or Section C

A. Spouse's Consent

I have read this Hardship Withdrawal Request Form and the Special Tax Notice. I understand that this withdrawal will reduce any subsequent distribution that may be payable from the Plan.

With this knowledge, I consent to the payment of this withdrawal to my spouse.

Spouse Signature

Date

Spouse Name (please print)

B. Witness to Spousal Consent

Notary Public:

Subscribed and sworn to before me this _____ day of _____, 20____

Notary Public _____ State of _____

Commission Expires _____

Notary's Signature _____ Date _____

C. Participant's Certification, If No Spouse

I hereby certify that I am not now married.

Participant Signature

Date

VII. AUTHORIZATION TO PAY SELF-PAY MEDICAL HARDSHIP TO HEALTH PLAN

Please sign only if you are requesting a hardship distribution to pay self-payments to maintain continued coverage under your Union Health Plan.

I hereby authorize the Sheet Metal Workers' Union Local No. 33 Profit Sharing Annuity Plan to pay the hardship withdrawal requested directly to my Union Health Plan.

Participant Signature

Date

Union Health Plan Name

Union Health Plan Address

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FOR OFFICE USE ONLY

☐ Approved ☐ Denied Plan Representative's Signature _____ Date _____

Note: The Plan will not process this withdrawal unless one box is checked in each of the following sections: IIA, IIB and III. The withdrawal will also not be processed unless both the participant and the plan representative sign this form.