



Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”)

Distribution Form

INSTRUCTIONS:

Please PRINT and complete ALL sections and ALL pages applicable to your plan on the form and SIGN at the end.

Section A: PLAN INFORMATION		
Contract/Plan/Subscriber Number	Plan Name	
Section B: PAYEE INFORMATION		
Name (First, Middle, Last)	Social Security Number	
Street Address		
City	State	Zip Code
Legal State of Residence		
If the Legal State of Residence is not provided, MassMutual will use the state provided in the Mailing Address for state tax purposes.		
Phone Number	E-mail Address	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Not Married or Legally Separated		
Section C: DISTRIBUTION AMOUNT		
Note: Up to Ninety Percent (90%) of account balance but amount cannot exceed \$30,000 (gross) unless a lower amount is established by your plan. The \$30,000 limit is applied based upon all plans maintained by the employer (and any member of the controlled group that include the employer). It is the Participant's responsibility to manage this and ensure the total withdrawn from all retirement accounts does not exceed \$30,000. Distribution is prorated across all investments.		
Gross Amount: Withdraw \$ _____ from my vested account balance. I understand that any income tax withholding will be deducted from this amount. If the amount available is less than requested, maximum amount available will be distributed.		
Section D: EMPLOYMENT STATUS & VESTING VERIFICATION (TPA or PA completes)		
Employment Status (select one): <input type="checkbox"/> Active <input type="checkbox"/> Retired/Retirement Date: ____/____/____ <input type="checkbox"/> Terminated/Termination Date: ____/____/____		
Vesting – Enter the Vested % for each employer contribution source: _____% (If multiple vesting schedules, provide vesting % for each.)		
TPA Signature (when applicable): _____		
Section E: FEDERAL INCOME TAX WITHHOLDING		
Distributions of pre-tax contributions plus interest on <u>all</u> contributions are subject to federal income tax. Federal income tax law requires that MassMutual withhold 10% of the taxable amount, unless you elect no withholding below. Federal income tax law requires that MassMutual withhold 20% of the taxable amount if the distribution is eligible for rollover. If no election is made, MassMutual will default to the required withholding. Please read the <i>Special Tax Notice</i> . Contact your tax advisor or the IRS if you have any questions concerning tax withholding.		
Participant Payee I have read the <i>Special Tax Notice</i> . I understand that a CARES Act withdrawal that is not eligible for rollover may have after-tax repayment options available and I should contact my Plan Sponsor with any questions. If withholding is elected below, MassMutual will withhold the amount indicated or required by law.		
I elect to have federal income tax: <input type="checkbox"/> withheld <input type="checkbox"/> not withheld		

In addition to this federal income tax withholding, I want an additional amount withheld of \$ _____

Section F: STATE INCOME TAX WITHHOLDING

Skip this Section if you reside in a state with no income tax or withholding requirement on retirement income.

The taxable portion of your payment may be subject to state income tax withholding requirements. While MassMutual will withhold based on your state's income tax rules and your election, if applicable, you are responsible for ensuring you satisfy your individual state income tax liability. If you make an election that is not compliant with your state's income tax withholding rules, then MassMutual will default to your state's income tax withholding requirements.

State Income Tax Withholding rules are subject to change at any time. For current state specific tax information pertaining to your resident state, you should contact your tax advisor or your state income tax department. Also note, state tax rules may apply differently depending on your type of distribution (i.e. lump sum, periodic, non-periodic, etc.). In addition, some states allow for an exclusion from income distributions from certain retirement plans – to confirm whether you may qualify to exclude all or a portion of your distribution from income for state taxation purposes, you should consult your plan sponsors or state income tax department.

If your state's income taxes are determined based on wage tables, MassMutual is unable to calculate a net amount, you will need to ensure that you have grossed up accordingly. There may be a delay if you request a net amount.

If you do not see your state listed below, it is a result of your state not permitting state income tax withholding.

Any tax information included in this written or electronic communication was not intended or written to be used, and it cannot be used by the taxpayer for purpose of avoiding any penalties that may be imposed on the taxpayer by any governmental taxing authority or agency.

Your state income tax withholding options are:

AR, DE, KS, MD, MA, NC, NE, VT, VA	<p>These states require mandatory state income tax withholding on taxable distributions. MassMutual is required to withhold state income taxes based on state law. You may not elect out of state income tax withholding.</p> <p>Requests for Required Minimum Distributions (RMDs) and installment payment programs over a period of 10 years or more are not eligible to be rolled over. If you chose to opt out of federal income tax withholding, MassMutual will automatically opt you out of state income tax withholding. If you did not opt out of federal income tax withholding, then MassMutual will withhold based on state law.</p> <p><input type="checkbox"/> I elect to withhold an amount of \$ _____ (whole dollar amount) OR _____ %</p>
CA, DC, IA, ME, OK, OR	<p>These states require mandatory state income tax withholding. MassMutual is required to withhold state income taxes based on state law unless you elect out of withholding. <input type="checkbox"/> I elect no state income tax withholding.</p> <p>Note: The District of Columbia only requires mandatory withholding on a "lump sum" distribution that brings your account balance to zero. If you are requesting a "lump sum" distribution, then you may not opt out of withholding.</p>
AL, AZ, CO, ID, IL, IN, KY, LA, MS, MO, MT, NJ, NM, NY, ND, OH, PA, RI, WV, WI	<p>These states permit voluntary state income tax withholding. You may voluntarily elect state income tax withholding by providing a dollar amount or percentage below. If no election is made for these voluntary states identified, then MassMutual will not apply any withholding.</p> <p><input type="checkbox"/> I voluntarily elect to withhold an amount of \$ _____ (whole dollar amount) OR _____ %</p> <p>Note: AZ and IL only permit voluntary state income tax withholding <u>on periodic payments</u>. If a tax election is requested on periodic payments and no amount or % is provided, MassMutual will default based on state rules. Lump sum distributions do not allow for state income tax withholding. If a tax election is requested on a lump sum distribution, MassMutual will not apply any withholding.</p> <p>If the additional amount is requested for periodic payments, please complete section below</p>
GA, MN, SC, UT	<p>These states permit voluntary state income tax withholding. You may voluntarily elect state income tax withholding by selecting the box below. If no election is made for these voluntary states identified, then MassMutual will not apply any withholding. Please note only Gross Distribution requests are permitted when applying state income tax withholding.</p> <p><input type="checkbox"/> Withhold based on my state's tax table formula, if applicable (MassMutual will apply the default tax allowance.)</p>
CT, MI	<p>These states require mandatory state income tax withholding. MassMutual is required to withhold state income taxes based on state law unless you provide an alternate dollar amount or percentage withholding instruction below, along with completing your state-specific W-4P withholding certificate and submitting it with this form. If a W-4P is not provided, MassMutual will default to your state's mandatory max withholding amount. Note: CT residents, W-4P is only allowed for partial distributions.</p> <p><input type="checkbox"/> I elect to withhold an amount of \$ _____ (whole dollar amount) OR _____ %</p>

Additional State Income Tax Withholding	I elect to have an additional _____ % or \$ _____ (whole dollar amount) of state income tax withheld from my payments. This amount will be in ADDITION to any withholding selected above.
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Section G: DELIVERY INSTRUCTIONS

☐ Direct deposit to a bank account of which I am an authorized account holder. To elect Direct Deposit, you must select either Checking or Savings and you must provide a voided check or a bank specification sheet from your bank for validation.

☐ Checking ☐ Savings Bank Name _____

Bank ABA/Routing (9 digits) _____ Bank Account No. _____

Please note that we can only send funds via direct deposit to banks with a valid U.S. routing number.

I understand that if I do not fully complete this section or the bank account information, I have provided is invalid, a check will be mailed. I understand that a reprocessing fee may be charged to my account if the direct deposit is declined by my financial institution. I also authorize MassMutual to initiate a debit to my account for any overpayment or payments made in error.

To help protect our customers' assets, MassMutual may independently validate bank and customer account information before processing Direct Deposit/EFT. If we are unable to independently validate the bank and customer account information or sufficient documentation to support the Direct Deposit/EFT is not provided, we will mail a check to the address of record. It should be noted that we are not always able to independently validate credit unions or smaller banks. If the account cannot be validated, a check will be mailed even if a voided check or financial instrument is submitted with distribution request.

☐ Send my payment by check. We will mail a check to you at the legal address provided in Section B.

Section H: SPOUSAL CONSENT

I am the spouse of the Participant. I hereby consent to the Distribution requested by the Participant as described above. I understand that I am not obligated to consent to this distribution and that this distribution may reduce the amount of any benefit I may be entitled to from the plan. I understand that my consent to the distribution is irrevocable and that I may obtain additional information about the potential impact on my benefit from the plan administrator prior to providing this consent.

Spouse's Signature

Date

Notary Public Signature

Date Commission Expires

Date

OR

If Not Notarized – Plan Administrator Signature

Date

Section J: PARTICIPANT CERTIFICATION and AUTHORIZATION

I certify and represent that I qualify for a Coronavirus Related Distribution based on the qualification criteria listed below. If all required items are not completed on this form, payment will be delayed. .

Coronavirus Related Distribution Qualification Criteria

- Diagnosed with SARS-CoV-2 or COVID-19 by a test approved by the Centers for Disease Control and Prevention
- Spouse or dependent is diagnosed with SARS-CoV-2 or COVID-19
- Experiences adverse financial consequences as a result of being quarantined because of SARS-CoV-2 or COVID-19
- Being laid off or furloughed or having work hours reduced because of SARS-CoV-2 or COVID-19
- Being unable to work due to lack of child care because of SARS-CoV-2 or COVID-19
- Closing or reducing hours of a business owned or operated by the individual because of SARS-CoV-2 or COVID-19

I understand by signing below I am certifying that this a Coronavirus-related Distribution, and I understand that I may be required to maintain and/or provide documentation to my Plan Sponsor and/or the IRS.

If electing direct deposit, by signing below I certify that I am an account holder on the bank account listed above.

Important Note for Participants with a Non-U.S. or Non-U.S. Territory residence address:

☐ Please check this box if you are not a resident of the United States or a United States Territory. If the current address is not an address within the U.S. or one of its territories, the Participant or Beneficiary receiving the distribution is required to fill out and return a *Citizenship Statement* form with the distribution request. Failure to provide a *Citizenship Statement* will result in U.S. Federal taxes being withheld at a rate of 30% for recipients with a non-U.S. residence address. Please ask your Plan Sponsor for a *Citizenship Statement* form or call MassMutual's Customer Service Center for a copy.

Participant

Date

Section K: PLAN ADMINISTRATOR AUTHORIZATION

By signing below, I certify, as Plan Administrator that I have obtained the participant's consent and authorization for the CARES Act distribution requested on this form. I further certify that I have verified the participant's eligibility for the distribution and advised the participant of his or her rights under the Plan as well as, any fees applicable to the distribution. As Plan Administrator, I agree that I am solely responsible for authorizing this distribution from the plan as well as any subsequent reporting requirements, and I have confirmed that this distribution is permissible under the terms of the plan, its intended operation and applicable law.

I understand that the proper tax treatment and other qualification criteria applicable to distributions pursuant to the CARES Act are subject to regulations to be issued by the Department of Labor and/or the Internal Revenue Service. It is solely my responsibility to ensure the plan complies with any such requirements. I agree that MassMutual shall have no responsibility or obligation for ensuring this distribution meets statutory or regulatory requirements.

Plan Administrator

Date

Section L: RETURN INSTRUCTIONS

After you have completed ALL sections on ALL pages applicable to your plan and SIGNED the form, please remit:

FAX:

216-267-3345, Attention: Ginny Craider

EMAIL:

Ginny.craider@benesys.com

Regular Mail Address:

Sheet Metal Workers Local 33 Profit Sharing Annuity Plan
12515 Corporate Dr
Parma, OH 44130

CORONAVIRUS RELIEF CERTIFICATION

Purpose of this Form: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) requires Participants who request a coronavirus-related distribution or a delay in payment of loans from their retirement account to certify that they meet the requirements for such relief. Please fill out the form below, sign, date, and return to the fund office to receive such a distribution and/or a delay in payments.

Name (First, Last, M.I.) _____

Address _____

Telephone _____

Social Security Number _____

Certification: The above-named Participant certifies that he or she has been impacted by the virus SARS-CoV-2/the coronavirus disease 2019 (CVOID-19) (referred to below as “the coronavirus”) in the following way(s) (check all that apply):

- ☐ I have been diagnosed with the coronavirus by a test approved by the Centers for Disease Control and Prevention.
- ☐ My spouse or other person I have claimed as a dependent on my income tax has been diagnosed with the coronavirus by a test approved by the Centers for Disease Control and Prevention.
- ☐ I have experienced adverse financial consequences as a result of being quarantined.
- ☐ I have experienced adverse financial consequences as a result of a furlough or lay off or having work hours reduced due to the coronavirus.
- ☐ I have experienced adverse financial consequences as a result of the closing or reduction of hours of a business owned or operated by me due to the coronavirus.
- ☐ I have experienced adverse financial consequences as a result of being unable to work due to lack of childcare due to the coronavirus.

By signing below, I certify that the above information is true and accurate. I understand that the Plan shall have the right to recover any benefit payments made in reliance on any willful, false or fraudulent statement, information, or proof submitted by an applicant for benefits. Any falsification made in this document could result in legal action against me by the Plan.

Signature

Date

CERTIFICATION OF MARITAL/SINGLE STATUS

Federal Law requires the Trustees to confirm whether a previous spouse is entitled to any portion of your pension benefits. As such, it is necessary that we request the following certification and supporting documentation. **Failure to complete this form fully, including signing it in front of a notary public, and providing ALL documentation requested, will result in a delay of the processing of your application.**

Participant Name: _____ SSN: _____

Current marital status: ☐ SINGLE, NEVER MARRIED
☐ SINGLE, PREVIOUSLY MARRIED*
☐ MARRIED, NO PREVIOUS MARRIAGES
☐ MARRIED, WITH PREVIOUS MARRIAGE(S)*
☐ LEGALLY SEPARATED*

Regardless of your marital/single status, please provide a copy of your birth certificate. If you are currently married, please provide a copy of your current marriage certificate and your current spouse's birth certificate.

*For each of your previous marriages, please list the name of your ex-spouse, the date of marriage and the date of divorce or separation (if any of your previous marriages ended due to the death of your spouse at the time, please list the date of death):

Ex-spouse's Name Date of Marriage Date of Divorce/Death

Please provide complete copies of ALL marriage certificates, divorce decrees, separation agreements, Qualified Domestic Relations Orders and any other accompanying documents related to the termination of your previous marriage(s). If any previous spouse(s) passed away, please provide a copy of the death certificate(s). If you do not have these documents, you should contact the appropriate court through which the proceedings occurred in order to obtain certified copies.

I hereby certify, subject to the penalty of perjury, that the above information is, to the best of my belief and knowledge, true and complete. ANY PERSON WHO SUPPLIES A FALSE CERTIFICATION IN CLAIMING A BENEFIT FORFEITS ANY RIGHT HE OR SHE MAY HAVE TO THE BENEFIT AND, UPON DISCOVERY, BECOMES LIABLE FOR FULL REPAYMENT OF ANY MONEY RECEIVED AS A CONSEQUENCE.

Participant Signature

Participant Social Security No.

Today's Date

Subscribed to and sworn to before me,
This _____ day of _____, 20____.
Notary Signature _____
Notary Public, _____ County
State of _____
My Commission expires _____

DO NOT SIGN AND DATE THIS FORM UNLESS YOU ARE IN THE PRESENCE OF A NOTARY.