



*We Deliver Performance*

Participant: \_\_\_\_\_  
Plan: \_\_\_\_\_  
Date: \_\_\_\_\_

You are receiving this package because you indicated an immediate financial need and have exhausted all other means by which to meet that need. For us to proceed with the distribution, we need you and your employer to complete the following form and return to Polycomp. **Keep a copy of signed and returned paperwork for your own files.**

DESCRIPTION	ACTION REQUESTED	RETURN TO POLYCOMP BY
<b>Hardship Withdrawal Notice and Election Form</b>	<p><b>Complete as follows:</b></p> <ul style="list-style-type: none"> <li>✓ Make sure your personal information is accurate, and your address is complete, including zip code and phone number.</li> <li>✓ Select the reason for taking the Hardship Withdrawal and elect how you would like to receive the distribution.</li> <li>✓ Indicate your election for Federal and State tax withholding from this distribution as well as if you wish to waive the 30- day wait period.</li> <li>✓ Sign and date the form where indicated.</li> <li>✓ Have your employer sign and date where indicated.</li> </ul>	<i>Two Weeks Before Funds are Needed</i>
<b>Special Tax Notice Regarding Plan Payments</b>	<ul style="list-style-type: none"> <li>✓ Read carefully prior to completing Notice of Distribution. We also recommend that you contact your personal tax advisor regarding the tax consequences associated with plan payments you receive.</li> </ul>	<i>Retain for Your Records</i>

**RETURN COMPLETED FORM TO:**

Polycomp Administrative Services, Inc.  
6400 Canoga Ave., Ste. 250  
Woodland Hills, CA 91367  
Fax: (818) 346-8672

**Polycomp Administrative Services, Inc. is a service provider. We do not process checks or hold trust assets. If after 2 weeks from submitting your form to us you have not received your check, please contact your employer. If you have any questions on how to complete this form, please call us at (818) 716-0111 or (800) 736-7090.**



## **HARDSHIP WITHDRAWAL - NOTICE AND ELECTION FORM**

*To be completed by the Participant and reviewed/approved by the Employer*

Plan Name: \_\_\_\_\_

### **PARTICIPANT INFORMATION**

Participant's Name: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Marital Status:  Married  Single  Legally Separated  
Birth Date: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Daytime Telephone Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### **REASON FOR HARDSHIP (CHECK ONE)**

- Unreimbursed medical expenses (as defined in IRC Section 213) incurred by me, my spouse or dependent(s)
- Purchase of my principal residence
- Payment of tuition or related educational expenses for the next 12 months for me, my spouse, or dependent(s)
- Payment necessary to prevent eviction or foreclosure on my principal residence
- Payment of Funeral Expenses for my parent, spouse, child or dependent
- Payment of expenses for the repair of damage to my principal residence that would qualify for a casualty loss deduction

### **WITHDRAWAL AMOUNT (SELECT ONE)**

- Gross Amount                      Withdraw \$\_\_\_\_\_ from my vested account balance. I understand that if I elect any income tax withholding it will be deducted from this amount.
- Net Amount                              Withdraw \$\_\_\_\_\_ from my vested account balance plus withdraw any income tax withholding as elected below.

**\*\*If the amount available is less than requested, the maximum available will be distributed to you.**



INCOME TAX WITHHOLDING OPTIONS

- Any taxable amount distributed to me as a hardship withdrawal is taxable to me at my regular income tax rate for the year in which received.
I may choose to have any Federal or California state income tax withholding rate applied to this hardship withdrawal, which means that I may elect to have zero withholding. I have indicated my withholding election below.
Unless otherwise indicated below, 10% of my distribution will be automatically withheld for Federal income taxes and 1% will be automatically withheld for California state income taxes. In addition, a 10% federal tax penalty for early withdrawal from a retirement plan will be applied to you annual tax return, unless the hardship is due to medical expenses as defined in IRC Section 213.

Federal income tax withholding (check one box):

- I do not want to have Federal income tax withheld from my hardship withdrawal.
I want to have % Federal income tax withheld from my hardship withdrawal.

State income tax withholding (not applicable to non-California residents)(check one box):

- I do not want to have State of California income tax withheld from my hardship withdrawal.\*
I want to have % State of California income tax withheld from my hardship withdrawal.

\*Polycomp will accommodate your withholding requests to the extent allowed by the investment company holding the funds.

PAYMENT INFORMATION

By signing below I am stating the following:

- I have received a copy of and read the Special Tax Notice Regarding Plan Payments.
The amount of the withdrawal does not exceed the amount necessary to relieve the immediate and heavy financial need as stated above.
I have obtained all distributions (other than hardship distributions) and all nontaxable loans from all plans maintained by my employer.
I elect to receive payment immediately, thereby waiving my right to a period of at least 30 days to consider this hardship.
I understand that fees pertaining to this Hardship Withdrawal may be deducted from my account and that I can contact Polycomp for more details on these fees.
I understand I will not be able to make salary deferrals to the plan and all other plans maintained by my employer for at least 6 months after I receive my hardship distribution, including all qualified and nonqualified plans of deferred compensation or any cash-or-deferred arrangement that is part of a cafeteria plan within the meaning of Code Section 125.

SIGNATURE

Plan Participant's Signature

Date

I have reviewed the request made by the Participant and approve a hardship withdrawal based on the statements and documentation provided by the Participant. I understand it is my responsibility to keep a copy of any documentation provided for the Plan's records:

Plan Administrator (Employer): Date:

Plan Administrator (Employer) Print Name:

If you have any questions on how to complete this form, please call us at (818) 716-0111 or (800) 736-7090. Completed form should be returned to: Polycomp Administrative Services, Inc., 6400 Canoga Ave., Ste. 250, Woodland Hills, CA 91367