



State of Rhode Island & Providence Plantations
 DEPARTMENT OF ADMINISTRATION
 Office of Employee Benefits
 One Capitol Hill
 Providence, RI 02908-5864
 Phone: (401) 574-8530 Fax: (401) 574-9281

DISTRIBUTION ELECTION APPLICATION

DEFERRED COMPENSATION (SEC. 457) PLAN

SECTION A - EMPLOYEE IDENTIFICATION

Name of Participant (Last, First, Middle) _____

Street _____ City _____ State _____ Zip Code _____

Date of Birth _____ Home Phone _____ Work Phone _____

IF ACTIVE EMPLOYEE, Agency Account Number _____

SOCIAL SECURITY NUMBER _____

SECTION B - INVESTMENT VENDOR

Voya (formerly ING) VALIC Fidelity Other

SECTION C - REASON FOR DISTRIBUTION

Termination of Employment _____ Under \$5,000 Death (Beneficiary must sign this form and attach a copy of the death certificate)

Retirement (Specify Date) _____ Q.D.R.O Plan to plan transfer to other vendor (for active employees - complete Section D on pg 1)

Disability (Specify Date) _____ Other Rollover (for retired/terminated employees – complete Section D on pg 1)

SECTION D - VENDOR TRANSFER/ROLLOVER

THIS IS TO REQUEST TRANSFER/ROLLOVER OF MY EXISTING DEFERRED COMPENSATION ACCOUNT INVESTMENT(S) AS FOLLOWS:

1. Transfer/Rollover _____% of my funds from: (Vendor) _____, Contract/Certificate A/C # _____

2. Transfer/Rollover funds to: (VENDOR) _____, Contract/Certificate A/C # _____

SECTION E - BENEFIT PAYMENT

Place a check mark beside the payment option you choose and indicate payment schedule:

Monthly Quarterly Semi-annually Annually

Option One Lump sum payment
 Option Two Payout over a fixed term (specify years) _____
 Option Three Fixed Amount (Specify) \$ _____ Until Exhausted
 Option Four Life Annuity Only (at death of payee no further payments are due)
 Option Five Life Annuity with Payments Guaranteed for _____ years.
 Option Six Joint and Last Survivor Annuity (Computed at: _____).

Other Option/Info _____ 100% 66-2/3% 50%

_____ With No Period Certain With _____ months certain

Joint Spouse - Name Social Security Number Date of Birth
Annuitant Other (Specify)

SECTION F - PARTICIPANT/BENEFICIARY SIGNATURE

I understand that by signing this application for a distribution election, when approved, will initiate commencement of benefits under the Plan according to the option selected.

SIGNATURE: Participant _____ Date _____

OFFICE USE ONLY

WITHDRAWAL DISAPPROVED (see reason below) WITHDRAWAL APPROVED

Incomplete Request Form
 Still and active employee
 Other (see attached)

Authorized Signature (Office of Employee Benefits) _____
Date