Public Employers Retirement Trust
Deferred Compensation
Application for Withdrawal

Print Name: _____

Employer: _____

Part A: Reason for Withdrawal

I hereby request a withdrawal from the Public Employers Retirement Trust due to:

____Termination of Employment
____Disability
____Retirement
____Death of participant (Please include a copy of the death certificate. Named beneficiary should complete this form, and include rollover instructions if applicable.)
____Transfer to another retirement plan approved by the employers' plan **(please include rollover instructions.)**
____De minimis exception
____Annual Required Minimum Distribution. (must start the year you turn 70 ½.)

Part B. Method of Distribution

I hereby request that any benefit to which I am entitled under the Plan be paid in the following manner:

____**One lump sum or portion thereof**, $_____ **** NOTE: 20% of the requested distribution will be withheld for federal taxes, and 4.25 for state taxes. Please take that into consideration when determining how much to request.**

____**Periodic payments for a designated period**,

$_____ per month / quarter / year (circle one)

____**Rollover to an Individual Retirement Account**.

NOTE: This option is only available after you have terminated employment with the employer that offered the plan, or have reached the age of 70 ½. **Please provide rollover instructions including name of new investment, address, and account number. Also include a letter of acceptance from the new investment company. Rollovers will occur at the end of the investment quarter.

____**Delayed distribution**. Please complete section C.

Part C. Delayed Distribution Election

I hereby elect to delay distribution of any amounts payable to me from the Public Employers Retirement Trust until:

____A specific future date (not later than April 1 of the calendar year following the year you reach age 70 ½) Future Date: Day____ Month _____ Year_____
____Upon my attaining age _____ (not later than 70 ½)
____Upon my attaining normal retirement age (age____)

Part D. Signatures

I understand that all distributions paid to me are reported as taxable income in the year distributed.

Date:_____

_____
Participant or Beneficiary Signature

_____
Street address

_____
City, State, Zip

_____
Social Security Number

Date:_____

PLAN TRUSTEE

_____
Plan Trustee Signature

_____
Plan Trustee Title

_____
Entity

Note: The Plan Trustee's signature is required on this document in order for our office to process your request. This form will be returned if not completed properly.

Send completed forms to: **PERT**
148 E. Grand River Ave., Suite 209
Williamston, MI 48895