December 17, 2019

{stdMbrFullName}

{x stdMbrAdrCorStreet1}

{x stdMbrAdrCorStreet2}

{x if stdIsUSA = 1}

{x stdDomesticStateInternationalCountry}

{x else}

{x stdDomesticStateInternationalCountry}

{x stdMbrAdrCountryDesc}

{endif}

**Re: IMPORTANT NOTICE – Required Minimum Distribution (RMD) Benefits**

**Individual Account Plan (IAP)**

Dear {stdMbrFullNameInProperCase}:

Our records show that you meet the following conditions that allow you to withdraw your IAP balance:

* You are, or you will soon be reaching Minimum Distribution age (April following the year you turn age 70 ½ years)
* You are vested in the Individual Account Plan (IAP)

**You have an estimated IAP benefit as of Plan Year** **{iintYear} of** **{PartBalBenAmt}.** You may withdraw this benefit per plan rules, by filling out and sending us the enclosed forms, by FAX or mail to the address indicated at the bottom of this letter. In addition, you will also need to provide a copy of your birth certificate for you and your spouse, marriage certificate and proof of Social Security number, if not already on file.

Your benefit, payment, if over $200, is subject to a mandatory 20% federal tax withholding unless a direct rollover to an IRA or other employer plan is made. More information about the tax ramifications of this payment is set out in the enclosed Special Tax Notice.

If you have any questions, please contact MPI’s Participant Services Center by email at [rsd@mpiphp.org](mailto:rsd@mpiphp.org) or call toll-free (855) ASK-4MPI (275-4674), from 8 a.m. to 5 p.m. Pacific Standard Time, Monday through Friday.

Sincerely,

Retirement Benefits

FAX (323) 877-2223

Enclosures

See your Summary Plan Description for additional information about the Plans. Benefits are subject to final verification, review and adjustment. If applicable, any amounts may be subject to change in accordance with any divorce or Qualified Domestic Relations Order (QDRO), which may or may not be on file. In the event of any inconsistency between any communications and the provisions of the Plans, the actual provisions of the Plans shall govern.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | **BIRTH DATE:** | {stdMbrDateOfBirth} |
| **SPOUSE:** | {stdMbrSpouseFullName} | | **BIRTH DATE:** | {stdSpouseDateOfBirth} |
| **TYPE:** | Minimum Distribution | **RMD WITHDRAWAL DATE:** | | {dtWdrwl} |

To the Board of Directors of the Motion Picture Industry Pension Plan (“Pension Plan”) and the Motion Picture Industry Individual Account Plan (“IAP”) (collectively “the Plans”):

This is to notify you that I, {stdMbrFullNameInProperCase}**,** intend to withdraw my balance from the IAP as of **{dtWdrwl}**.

**PLEASE READ CAREFULLY BEFORE SIGNING**

**I understand that:**

1. I am voluntarily electing to withdraw my balance under the IAP. The IAP does not require me to withdraw my balance.
2. I am not applying to retire from the Pension Plan and my eligibility for any Pension Plan benefits will be determined separately.
3. I cannot repay my distributions to the IAP under any circumstances.
4. Before any payment(s) can be made, I must provide to the Plans proof of my date of birth, Social Security number and, if married, my spouse's date of birth and marriage certificate. In addition, if applicable, I must provide a conformed copy(ies) of the final judgment with the property settlements and agreements and/or death certificate(s) for previous spouse(s) during my participation under the Plans to verify that my prior spouse(s) has no claim to any portion of benefit.
5. If I return to work after my Withdrawal Date, my IAP benefits will be reviewed on a yearly basis for additional benefits I may have earned.
6. The benefit payable to me is subject to final verification, review and adjustment.

**PARTICIPANT’S CONSENT**

I understand that if the Plans do not receive my completed application prior to my withdrawal date, it will become invalid and moved to the 1st of the month following the date my application is received. In addition, all supporting documents must be received within sixty days of the date my application is received to avoid automatic cancellation.

Under penalty of perjury, I certify that my current marital status is: Single Married Divorced Widowed

My citizenship status *(required for tax purposes)* is: U.S. Citizen U.S. Resident Alien Other

My signature on this document indicates that I have read and understand the terms and conditions of this application.

Participant’s Signature Date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | **BIRTH DATE:** | {stdMbrDateOfBirth} | |
| **SPOUSE:** | {stdMbrSpouseFullName} | | **BIRTH DATE:** | {stdSpouseDateOfBirth} | |
| **TYPE:** | | Minimum Distribution | **RMD WITHDRAWAL DATE:** | | {dtWdrwl} |

**BENEFIT ELECTION**

|  |  |  |
| --- | --- | --- |
| **Initial One** | **Benefit Option** | **Payment Amount\*** |
|  | 1. **Life Annuity** (Default option for unmarried Participants) | **{PartIAPLifeAnnuity}** |
|  | 1. **Qualified Joint and 50% Survivor Annuity** (Default option for married Participants) | **{PartIAPJS50}** |
| *Spouse’s Benefit at Participant’s Death* | *{SpouseIAPJS50}* |
|  | 1. **Joint and 75% Survivor Annuity** | **{PartIAPJS75}** |
| *Spouse’s Benefit at Participant’s Death* | *{SpousetIAPJS75}* |
|  | 1. **Joint and 100% Survivor Annuity** | **{PartIAPJS100}** |
| *Spouse’s Benefit at Participant’s Death* | *{SpouseIAPJS100}* |
|  | 1. **Ten-Years-Certain and Life Annuity** | **{PartTenYr}** |
|  | 1. **Lump-Sum Payment** | **{PartIAPLumpSum}** |

**SEE REVERSE FOR BENEFIT PAYMENT OPTION DESCRIPTIONS**

**\* All amounts are an estimate based on current balances and marital status, and subject to verification before payment.** Benefit amounts will not be listed under the Joint and Survivor Annuity options if you are unmarried. The beneficiary for a Joint and Survivor Annuity must be the spouse to whom you are married at the time of retirement regardless of divorce or remarriage during retirement. The beneficiary for a Ten-Years-Certain and Life Annuity must be your spouse and/or children.

**BENEFICIARY DESIGNATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | | Relationship  Spouse Child |
| Social Security Number | Birth Date (MM/DD/YYYY) | Beneficiary Type  Primary Contingent %: | |
| Mailing Address | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | | Relationship  Spouse Child |
| Social Security Number | Birth Date (MM/DD/YYYY) | Beneficiary Type  Primary Contingent %: | |
| Mailing Address | | | |

**PARTICIPANT’S CONSENT**

I understand that I may only revoke this benefit election during the 30-day period immediately preceding my withdrawal date. I understand that, upon withdrawal, this benefit election is irrevocable. I certify that all of the foregoing information is true and correct.

Participant’s Signature Date

**SPOUSE’S CONSENT**

I acknowledge that if my spouse elects to receive benefits other than a Qualified Joint and 50% Survivor Annuity from the IAP, my signature below waives such Joint and Survivor Annuity. This consent is voluntarily given and no undue influence or coercion has been exercised in connection with my decision to give this consent.

Spouse’s Signature **(Must be Witnessed Below)** Date

Subscribed and sworn to before me on this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_, by {stdMbrSpouseFullName} ,proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

(NOTARY STAMP)

**Signature of MPI Representative or Notary Public in and for said County and State**

**MOTION PICTURE INDUSTRY INDIVIDUAL ACCOUNT PLAN (IAP)**

In general, unless a lump sum benefit is selected, the type of benefit payment will automatically be a monthly annuity benefit. If your balance is over $5,000, you may elect to receive the balance in a lump sum payment or a monthly annuity purchased from an insurance company.

1. **Life Annuity**

This option provides a monthly lifetime benefit payment to the Participant only. No benefit will be paid to any survivor. This is the only option available to unmarried participants with no children.

1. **Qualified Joint and 50% Survivor Annuity**

The Employee Retirement Income Security Act of 1974 (ERISA) requires a married Participant to retire with a Qualified Joint & 50% Survivor Annuity unless the Participant elects another available option with their spouse’s written consent. Under this option, you will receive a reduced monthly benefit (based on your age and your spouse’s age) throughout your lifetime. If you predecease your spouse, a lifetime monthly benefit will continue to be paid to your surviving spouse at an amount equal to one-half of the monthly benefit received while you were living. Regardless of divorce or remarriage during retirement, the Joint & 50% Survivor Annuity must be paid to the spouse you were married to on your retirement date.If your spouse predeceases you after your retirement date, the Joint & 50% Survivor Annuity will continue for your lifetime at the same reduced monthly amount; no benefit will be paid to any survivor, including a new spouse if you remarry after retirement.

1. **Joint and 75% Survivor Annuity**

This option is similar to the Qualified Joint & 50% Survivor Annuity except that there is less of a reduction in benefit to your surviving spouse in the event of your death. In the event of your death, a lifetime monthly benefit will continue to be paid to your surviving spouse at an amount equal to 75% of the monthly benefit received while you were living. The monthly benefit payment during your lifetime is lower than that received through the Qualified Joint & 50% Survivor Annuity.

1. **Joint and 100% Survivor Annuity**

This option is similar to the Qualified Joint & 75% Survivor Annuity Benefit except that there is no reduction in benefit to your surviving spouse in the event of your death. The monthly benefit payment during your lifetime is lower than that received through the Qualified Joint & 75% Survivor Benefit.

1. **Ten-Years-Certain and Life Annuity**

This option provides you with a monthly lifetime Pension benefit. In the event of your death within 10 years of your retirement date, your beneficiary will receive the same monthly benefit amount for the remainder of the 10-year period. Following this 10-year period, the benefit payments to your beneficiary will permanently cease. If you die after the 10-year period following your retirement date, no benefit will be provided to your beneficiary. If you retire under this option and are re-employed, the 10-year period shall not be increased by the re-employment period.

1. **Lump-Sum Payment**

If your balance is $5,000 or less, your benefit will be automatically paid in a single lump sum. If your balance is over $5,000, you may elect, with spousal consent, to take the entire value of the benefit in a single lump sum. If you elect a lump sum and your balance is equal to or greater than $200, it is subject to a mandatory 20% Federal tax withholding, unless you roll it over into an IRA or other qualified plan.

**Annuity Purchase Option under the lAP:**

If you elect from Option 1,2, 3, 4 or 5, the Plan Office will purchase an annuity for you from an insurance company using your account balance. You will receive a monthly benefit from the insurance company.

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| ***Pursuant to the provision of the Motion Picture Industry Pension and Individual Account Plans (the ''Plans''), the Plans are authorized to distribute the funds in accordance with the Option I have selected below. I understand that the distribution process may be delayed or cancelled if this form along with the application is not received by the Plan Office within 60 days from your application date.*** | | |
| **RECIPIENT’S NAME** | **MPID** | **DISTRIBUTION AMOUNT** |
| {stdMbrFullNameInProperCase} | {stdMbrParticipantMPID} | *{PartLumpSumBenAmt} (through* *{LumpSumYear})* |

|  |  |
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| Please refer to the Information about the tax treatment of distributions in the accompanying Special 402(f) Tax Notice Regarding Plan Payments. The Plans strongly recommends you discuss the distribution options below with a tax professional. | |
| **Check only one option under Section A.**  **If you choose option 2 or 3, page 2 must be completed by the custodian of your IRA or other qualified plan.** | |
| If you do not elect to rollover all or a portion of your distribution directly to an IRA or other qualified plan, the Plans will automatically withhold 20% in federal income taxes from that distribution. | |

|  |
| --- |
| **SECTION A: Distribution Type Election** (select only one) |
| **Option 1:** Please issue a check for the balance payable to me. I do not elect a direct rollover of my distribution. I understand that mandatory 20% federal income tax and 2% California State income tax (if elected) will be withheld. |
| *{x if IsRETR = 1} To qualify for the options below, the taxable portion of the payment must be $750 or more.*  *{else} To qualify for the options below, the taxable portion of the payment must be $200 or more.*  *{x endif}* {elsex |
| {x if IsRETR = 0} {endif}  **Option 2:** I elect to rollover the entire distribution into my IRA or qualified plan.  **Option 3:** I elect to rollover a portion of my distribution directly into my IRA or qualified plan. The amount I would like to rollover is indicated in the Rollover Amount box on the top of page 2. I understand that a separate check will be issued for the balance of the taxable portion, less applicable federal and state income tax withholding, plus the entire non-taxable portion, if any.  **My Trustee/Custodian and I must complete page 2** |

|  |
| --- |
| **SECTION B: Tax Resident Status** |
| My citizenship status is *(required for tax purposes)*: U.S. Citizen or Resident Alien Non-Resident Alien\*  *\* IRS Form W-8 is required for non-resident alien claiming tax treaty benefits.* |
| **SECTION C: State Income Tax Withholding Election** (for California residents only) |
| I understand that unless I select the box below, 2% California State income tax will be withheld from any portion of my distribution that is not rolled over to a qualified plan. I understand that my actual federal or state income tax liability may exceed the amount withheld by the Plans from the distribution to me. I understand that I may be subject to tax penalties under the estimated tax payment rules if my estimated tax payments and withholding are inadequate. |
| Do NOT withhold California state tax *(I understand this choice does not relieve me of any tax liability)* |

**RECIPIENT’S CONSENT**

My signature on this document indicates that I authorize the Plans to distribute the funds in accordance with the option I selected above and that I have reviewed the Plans’ *Summary Plan Description* terms and conditions as well as the Special Tax Notice 402(f) Regarding Plan Payments. If I elect Options 2 or 3, I authorize the IRA or employer plan identified on page 2 to accept a rollover on my behalf. I understand that my check will be processed based on the information herein. I will notify the Plans if there are any changes to this information.

Recipient’s Signature Date

**PAGE 2: ROLLOVER ACCOUNT INFORMATION AND AUTHORIZATION**

To be completed only if choosing Option 2 or Option 3

|  |  |  |
| --- | --- | --- |
| **RECIPIENT’S NAME** | **MPID** | **ROLLOVER AMOUNT** |
| {stdMbrFullNameInProperCase} | {stdMbrParticipantMPID} |  |

|  |
| --- |
| Must be completed by the custodian of your IRA or qualified plan |

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION D: Rollover Account** | | | |
| **Type of IRA or Plan:**  IRA – Sec 408(a) Roth IRA – Sec 408(a)  Annuity – Sec 408 (b) Annuity – Sec 403(a) Annuity – Sec 403(b)  Qualified Trust/Plan – Sec 401(a) Government Deferred Compensation Plan – Sec 457(b) | | | |
| **MAKE CHECK PAYABLE TO:** | (Trustee/Custodian of IRA/Qualified Plan) | | |
|  | | |
| **Account Number** (Please DO NOT use Social Security Number) | | | |
|  | | | |
| **PAYMENT HANDLING INSTRUCTIONS** | | | |
| **Check will be mailed to:** | | | |
| **IRA or Plan Contact Name** (Required if Account Number field is not completed) | | | |
|  | | | |
| **Address** | | | |
|  | | | |
|  | |  |  |
| **City** | | **State** | **Zip** |
|  | |  |  |
| I declare that the IRA or employer plan identified above will accept a rollover on behalf of the recipient hereof. I declare that I am authorized to act on behalf of the financial institution, the IRA or employer plan identified above. | | | |
| Trustee/Custodian’s Signature Date | | | |
| **Trustee/Custodian’s Name** | | **Title** | |
|  | |  | |
| **Email** | | **Phone** | |
|  | |  | |