|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | | | | **BIRTH DATE:** | | | {stdMbrDateOfBirth} | |
| **SPOUSE:** | {stdMbrSpouseFullName} | | | | | **BIRTH DATE:** | | | {stdSpouseDateOfBirth} | |
| **WITHDRAWAL DATE:** | | {dtRetirementDate} | **PLAN:** | {istrLocalPlan} |  | |  |  | |  |

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

This is to notify you that I, {stdMbrFullNameInProperCase}, intend to withdraw my balance from the IAP that I accrued from the {istrLocalPlan}, I.A.T.S.E. Annuity Fund (the “Special Account”) on **{dtRetirementDate}**.

**PLEASE READ CAREFULLY BEFORE SIGNING**

**I understand that:**

1. I am voluntarily electing to withdraw my balance under the Special Account. The IAP does not require me to withdraw my balance.
2. Except as provided below, I will receive a benefit in accordance with my election under the Special Account. I am not requesting any Pension Plan benefits at this time.
3. I may withdraw the balance in the Special Account when I attain age {if istrIsLocal52 = Y}59 ½. Prior to age 59 ½, I may withdraw the balance in the Special Account if I have a three-month{else} 57 (or the fifth anniversary of my commencement of participation in the Plan, if later). Prior to age 57, I may withdraw the balance in the Special Account if I have a six-month{endif} consecutive period without earning any Credited or Vested Hours under the MPI (distributions will not be made until the Plans verify this, and no distribution will be made if the Plans learn that I have returned to work during this verification period).
4. I cannot repay my distribution to the IAP under any circumstance.
5. 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 MPI to verify that my prior spouse(s) has no claim to any portion of my benefit.
6. The benefit payable to me is subject to final verification, review and adjustment.

**PARTICIPANT’S CONSENT**

I understand that if MPI does 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} |
| **WITHDRAWAL TYPE:** | {istrLocalPlan} Special Account | **WITHDRAWAL DATE:** | | {dtWdDate} |

|  |  |  |
| --- | --- | --- |
| **Initial**  **One** | **Benefit Option** | **Payment**  **Amount\*\*** |
|  | 1. **Life Annuity**   (Default option for unmarried Participants) | **{PartLife}** |
|  | 1. **Joint & 50% Survivor Annuity**   (Default option for married Participants) | **{PartJS50}** |
|  | 1. **Joint & 75% Survivor Annuity** | **{PartJS75}** |
|  | 1. **Single Lump-Sum Payment** | **{PartLumpSum}** |

**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 & Survivor Annuity options if you are unmarried. The beneficiary for a Joint & Survivor Annuity must be the spouse to whom you are married at the time of retirement regardless of divorce or remarriage during retirement.

**BENEFICIARY DESIGNATION**

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | | Relationship |
| 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

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**

**SPOUSE’S CONSENT**

I acknowledge that if my spouse elects to receive benefits other than a 50% Joint & Survivor Annuity, my signature below waives such Joint & 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

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

**(LOCAL 52/LOCAL 161)**

**Annuity Purchase Option under the lAP:**

The Plan Office will purchase an annuity for you from an insurance company using your account balance. You will receive a monthly benefit from a insurance company.

1. **Life Annuity:**

The monthly Life Annuity Benefit ceases upon the death of a Participant. No monthly benefits are paid to any survivor.

1. **Joint & 50% Survivor:**

This is the automatic form for married Participants unless the Participant and the Spouse\* elect another form. This monthly benefit is an amount which is actuarially reduced from the amount of the Benefit in item "1" above. After a Participant's death, if the Participant's Spouse is still alive, the Benefits will continue to the Spouse for his/her lifetime. The surviving Spouse will receive 50% of the amount paid to the Participant. If the Spouse dies and the Participant is still alive, the benefit amount will not change and will be paid to the Participant for his/her lifetime.

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

This monthly benefit is an amount that is actuarially reduced from the amount of the benefit in (1). After a Participant's death, if the Participant's spouse named above is still alive, such benefits continue to such spouse as long as such surviving spouse lives. The surviving spouse will receive 75% of the amount paid to the Participant. If the spouse named above dies, and the Participant is still alive, the benefit will not change and will be paid for the Participant's life.

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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})* |

|  |  |
| --- | --- |
| **Distribution Type:** | ***{DistributionType}*** |
| 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. | |

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| --- |
| **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}*  {x if PlanId = 0} {else} Employee Contributions and Unclaimed Vacation & Holiday Pay (UV&HP) are non-taxable. Interest on these items is taxable. {x |
| {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** |

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| **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.* |

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| **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} |  |

|  |  |
| --- | --- |
| **Distribution Type:** | ***{DistributionType}*** |
| 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** | |
|  | |  | |