

Election of Benefits Withdrawal Form – IRA



Southern Medical Association

3500 Blue Lake Drive - Suite 360 / Birmingham, AL 35243 / 800) 423-4992 / Fax: (205) 945-1830 / retirement@smaservicesinc.com

1. Account Holder Information *(Account Holder to Complete)*

Account Holder Name: _____ Social Security Number: _____

Account Holder Address: _____

City: _____ State: _____ Zip: _____ Use Address on Record

Plan Number: _____ Email Address: _____

Daytime Phone Number: _____ Date of Birth: ____/____/____

U.S. Citizen: Yes No, Country of Citizenship: _____

U.S. Resident: Yes No, Country of Residence: _____

Type of Withdrawal

Rollover Cash Payment Installment Payment RMD Charitable Distribution

Type of Benefit Election

Direct Rollover

By choosing this type of benefit election, I understand that I am irrevocably designating the specified portion of my vested account as a direct rollover contribution to the account or plan identified below. Due to the important tax consequences related to a direct rollover, I have been advised to confer with my attorney or tax advisor. I understand that once this rollover has been made, it is irrevocable.

Into an Individual Retirement Account (IRA) *Your IRA should be established before transfer of funds to your financial institution.*

Traditional IRA _____ % or \$ _____

Financial Institution: _____

Financial Institution Address: _____

City: _____ State _____ ZIP _____

Account Number: _____ Financial Institution Telephone Number: _____

Qualified Retirement Plan sponsored by your current employer _____ % or \$ _____

Plan Name: _____

Plan Administrator: _____

Financial Institution: _____

Financial Institution Address: _____

City: _____ State _____ ZIP _____

Account Number: _____ Financial Institution Telephone Number: _____

Cash Payment of 100% or Specific amount \$ _____ or _____ %

Installment Payments

Receive a payment in the amount of \$ _____ Monthly Quarterly Semi-annually Annually

Date of 1st payment _____ *(Payments will be processed on the 2nd working day of the month.)*

*If selecting the installment option, please complete the attached ACH Authorization.

Required Minimum Distribution (RMD) \$ _____ Year Ending: _____

You must receive a Required Minimum Distribution from your retirement account in this plan starting with the year you meet the following criteria:

You have reached age 72

You have a beneficiary of an account that is required to take a Required Minimum Distribution.

Qualified Charitable Distribution Instructions

- Required Minimum Distribution (RMD) for the current year *(not available on Roth IRA)*
- Other Amount *(not to exceed \$100,000)*: \$ _____

Legal Name of Charity: _____ Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Instructions

Use this section to make qualified charitable distribution (QCD) from your traditional IRA.

- The distribution check will be made payable directly to the charitable organization.
- The \$100,000 limit is the aggregate amount of the qualified distribution made from all of your IRAs.
- You must have attained age 70½.
- Amounts withdrawn over your allotted penalty-free amount are subject to surrender charges. Information regarding this can be found in your prospectus and/or policy pages.
- Please confirm that the organization you designate is eligible to receive QCDs. Ameritas Life is not responsible for making this determination
- Please retain a copy for your own records and contact the charitable organization directly for a gift receipt.
- Federal withholding will not be withheld from this distribution.
- The QCD will be reported to the IRS on Form 1099-R as a normal distribution based on your age. It is your responsibility to document the tax-free qualification to the Internal Revenue Service (IRS) on your Federal Income Tax return.
- Contact your own tax professional if you have any questions about this or any other tax matter.

Tax Withholding

Federal Tax Withholding

- 10% unless you choose to opt out

Choose one:

- Withhold the required percentage per IRS regulations
- Withhold the required percentage PLUS this additional amount: \$ _____ or _____%
- Do not withhold

State Tax Withholding

Choose one:

- Withhold the required percentage PLUS this additional amount: \$ _____ or _____%
- Do not withhold unless required by the state.

Delivery Instructions

Cash Proceeds Delivery Options	Cost to You	Information Required
<input type="checkbox"/> Check – U.S. Mail	\$0.00	• Valid Address – P.O. Box Allowed
<input type="checkbox"/> Check – Federal Express overnight	\$25.00	• Street Address – No P.O. Box Allowed • Day Time Phone Number
<input type="checkbox"/> ACH – Cash Payment or Installment only Not allowed for rollovers.	\$0.00	• Complete Attached ACH Authorization (see next page)
<input type="checkbox"/> Wire – Cash Payment or Installment only Not allowed for rollovers.	\$25.00	• Complete Attached ACH Authorization (see next page)

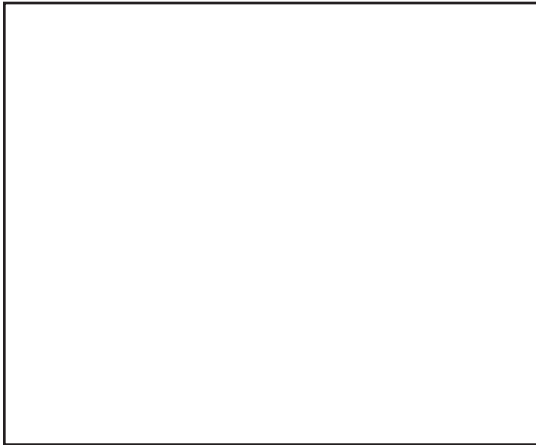
*If a P.O. Box is provided and Federal Express overnight is selected, then the check will be mailed via U.S. Mail. If a delivery option is not selected, then the check will be mailed via U.S. Mail.

2. Account Holder Sign and Date

Acknowledgment: I understand that SMA Services, Inc. (SMA) will not process distribution requests solely initiated by an incoming phone call. This account verification procedure can include verifying an email address, making an outgoing call to the account owner, account number verification and signed withdrawal forms. When a signed distribution form is received by SMA, they will call the phone number they have on file, to verify the validity of the request. In the event SMA is unable to verify the request, the distribution will not be processed.

X _____
Signature of Account Holder Date

Notarized Identity Verification of Account Holder – Required for withdrawals of \$250,000 or more.



State of _____ County of _____

Subscribed and affirmed before me on this _____ day of _____, 20____.

by _____

(Account Holder) proved to me on the basis of satisfactory evidence to be the person who appear before me.

X _____
Signature of Notary Public

3. Third Party Administrator Information *(TPA to Complete, if applicable)*

Third Party Administrator (TPA) Fee

Does any TPA withdrawal Fee apply? Yes \$ _____ No

X _____
Signature of Third Party Administrator Date

Please return this form by email, fax or mail:

Email: retirement@smaservicesinc.com

Fax: (205) 945-1830

Mail: Southern Medical Association, 3500 Blue Lake Drive, Suite 360, Birmingham, AL 35243

Authorization Agreement (ACH/EFT or Wire)

Complete all items listed below for your electronic fund transfer or there could be delays in processing.

- Rollover distributions cannot be issued with an ACH or wire payment. If you provide ACH information for a rollover distribution, the rollover distribution payment will be issued by check. If you provide wire information for a rollover distribution, the rollover distribution payment will be issued by check and sent Federal Express. A wire payment or Federal Express delivery are the same \$25 cost to you.
- If all the information below is not completed, then a check will be mailed to the address on the form.

1. Type of Account Identification: We require one of the following to process your cash out distribution request. *(Select one below)*

This form may only to be used for electronic transfer requests between Ameritas and your authorized Bank account.

- Voided Check Bank Letterhead with Routing & Account # A clear picture of your State issued ID or passport

2. Account Holder: Name _____

3. Type of Account: Checking Account Savings Account

4. Bank Information:

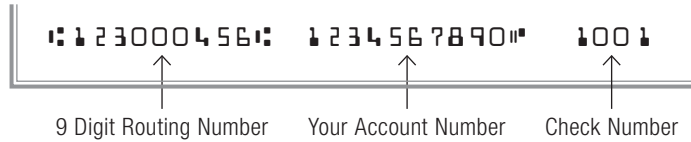
- Direct Deposit – No Charge (ACH/EFT) Wire – \$25 cost

Bank Name Information: _____ **You must be a signer on the below account listed.**

City: _____ State: _____ Zip: _____

Bank Routing Number: Bank Account Number: _____

Some banks have different routing numbers for wire transfers, so please ensure you have the correct number.



5. Please attach your voided check, bank letterhead with routing and account number or photo ID below.

This agreement is to remain in full force and effect until Ameritas Life Insurance Corp. has received notification from me of its termination in such time and manner as to afford Ameritas and the Bank a reasonable opportunity to act on it. I understand this authorization is for benefit payments from my Retirement Plan account.

I hereby authorize Ameritas Life Insurance Corp. to initiate appropriate credit entries to my bank account above, hereinafter called Bank.

This form must to be accompanied with your Ameritas Election of Benefits form, otherwise delays may take place in processing your request.

6.

Print or Type Name

X _____
Signature of Account Holder

Date: _____/_____/_____

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