



The City of Seattle
Voluntary Deferred Compensation Plan
Distribution Request of Qualified Health
and Long-Term Care Insurance Premiums

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Participant Information

Employer Name: City of Seattle Plan ID Number: 0056120001

Name: _____ SSN or Account #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone: _____

Email: _____

How would you like to be contacted if additional information is required? Phone Email

Distribution of up to \$3,000 Pre-Tax

I am an Eligible Retired Public Safety Officer of **City of Seattle**. I am entitled pursuant to Internal Revenue Code Section 402 to elect to have a portion of my qualified health and/or long-term care insurance premiums deducted on a pre-tax basis from my Defined Contribution Plan and paid directly to my Insurance Company.

Amount of Withdrawal: \$ _____ (up to \$3,000)

I am enrolled in the City of Seattle Health Plan.

NOTE: Contact the City Benefits Unit at 206-615-1340 or benefits.unit@seattle.gov prior to requesting the distribution to ensure the payment is applied correctly.

Your payment will be directed to:

City of Seattle Department of Human Resources
PO Box 34028
Attn: Benefits Unit - Health Ins
Seattle, WA 98124-4028

I am **not** enrolled in the City of Seattle Health Plan. Provide your Insurance Company's information below:

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy or Account #: _____ Phone: _____

- I hereby certify that the health insurance and/or long-term care premiums for which I have elected the withdrawal reflected above are qualified health insurance and/or long-term care premiums and therefore will fund only coverage for myself, my spouse and/or my dependents (within the meaning of Internal Revenue Code Section 152).
- I hereby certify that I have not, and will not, request a pre-tax withdrawal of health and/or long-term care insurance premiums from any other plan.
- **The amount elected will be paid to the requested insurance company.**

Additional Distribution for an Amount Greater than \$3,000

NOTE: If you are requesting a distribution greater than \$3,000, please request the additional amount below. It is your responsibility to send the remaining funds to the insurance company to ensure the policy remains in force and funded. The gross amount is the amount that will be processed before taxes are withheld. The net amount is the amount you will receive after taxes are withheld.

Gross Amount of: \$ _____

OR

Net Amount of: \$ _____

Payment Method (select one)

NOTE: Direct Deposit ACH is not available to financial institutions outside of the United States.

- Direct Deposit ACH on file:** Send funds to my bank account that Nationwide has on file.
- Mail Check:** Send check by first class mail to my address of record. Allow 5-10 business days from process date for delivery. If no other option is selected, your payment will be issued by check and mailed.
- Overnight Check:** I authorize Nationwide to send my payout check to me via overnight check to my address of record for a fee of \$25 deducted from my account. PO Box addresses are not eligible for overnight delivery and Saturday delivery may not be available in your area. Allow 2-4 business days from process date for delivery.
- New Direct Deposit ACH Authorization:** Send funds to the financial institution indicated below.

Financial Institution Information:

Financial Institution Name _____

Account Type: Checking Savings
If account type is not selected, checking will be used.

ACH Routing Number _____

Account Number _____

John Doe
123 Main Street Ph. (916) 555-1212
Hometown, CA 98765

Date _____ 1492

PAY TO THE ORDER OF _____ \$ _____
DOLLARS

Money Bank, Inc.
321 Main Street
Hometown, CA 98765

MEMO _____

⑆ 123456789 ⑆ 000012345678 ⑆ 1492

9-digit ABA routing number Checking Account Number Check Number

Account Verification: The following documents are required to verify ownership of the account provided:

- **Checking Accounts:** Please include a pre-printed voided check with this authorization.
- **Savings Accounts:** Please include a letter from the bank, signed by a bank representative, which indicates the ABA routing number, the account number and the account holder's name for verification.

NOTE: Direct Deposit is only offered through members of the Automatic Clearing House (ACH). We cannot accept a deposit slip or starter check for banking numbers.

Is this account associated with a brokerage firm or other investment firm? Yes No

If yes, have you confirmed that the ABA and account numbers are correct? Yes No

I hereby authorize Nationwide to initiate automatic deposits to my account at the financial institution named above. In the event an error is made, I authorize Nationwide to make a corrective reversal from this account. Further, I agree not to hold Nationwide responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. This agreement will remain in effect until Nationwide receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit authorization form to Nationwide. **In the event this direct deposit authorization form is incomplete or contains incorrect information, I understand a check will be issued to my address of record.**

Income Tax Withholding for Amount Greater Than \$3,000

Withholding election for lump sum and systematic distributions lasting less than 10 years:

Federal income tax withholding: Taxes will be withheld based on the 402(f) Special Tax Notice. There is a mandatory 20% withholding for federal income taxes. You may elect to withhold an additional amount over the mandatory 20%.

Line 1: Mandatory _____ 20 %

Line 2: Any additional amount _____ % OR \$ _____

Add percents from Line 1 and Line 2 and carry down the dollar amount from Line 2 for line 3 Total.

Line 3: Total federal withholding _____ % AND \$ _____

State income tax withholding: Taxes will be automatically withheld if you are a resident in a state that mandates state income tax withholding. If you would like to adjust your state taxes, please complete and attach a state tax withholding form. These forms can be obtained from the State website; Nationwide does not supply these forms.

Tax ID Certification

NOTE: Backup withholding does not apply to retirement plan distributions. FATCA does not apply as this is a U.S. account.

Under penalties of perjury, I certify that:

1. The Taxpayer Identification Number or Social Security Number listed on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because:
 - a. I am exempt from backup withholding, or
 - b. I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
 - c. The Internal Revenue Service has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person, and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Authorization

With respect to this election and authorization, I understand and certify the following:

- This election and authorization is only effective up to an annual aggregate maximum of \$3,000. This annual maximum applies to a calendar year with respect to distributions from all governmental defined benefit or defined contribution plans, 403(b) plans and 457(b) plans in which I participate. I am responsible for applying this limit.
- Any distributions made pursuant to this form will apply toward any minimum distributions required pursuant to Internal Revenue Code Section 401(a)(9) for the taxable year.
- Nationwide will make payment directly to the above insurance company, if my paperwork is received in good order no later than 14 calendar days prior to the due date. I further understand that Nationwide is not permitted to make payment to me or any other person.
- This form is not effective until signed by me and certified by the Plan Sponsor.
- If I have requested less than \$3,000 on this form, I understand that I must submit an additional Distribution Request form for another premium payment in the current calendar year up to the annual aggregate maximum of \$3,000.
- I hereby direct Nationwide to make a withdrawal from my Defined Contribution Plan for the purpose of paying up to an annual aggregate maximum of \$3,000 for my premiums for coverage under the above policy and to remit said amount directly to the Insurance Company. Please note that this form must be received in good order no later than 14 calendar days prior to the due date of the premium payment.

I hereby agree to the terms of this form and certify that the information provided above is true, accurate and complete.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Participant Signature: _____ Date: _____

Plan Authorization

This information must be completed by City of Seattle Plan Staff for the distribution to be processed.

I certify that this participant is a retired Public Safety Officer and is eligible to request this payment. Further, I certify that the health or long-term care insurance plan described by the participant in the "Payment Information" section of this form is a qualified health or long-term care insurance plan.

Date Participant Separated from Service: _____

Authorized Plan Representative:

Name (print): _____ Title: _____

Signature: _____ Date: _____

Submit Form Return

Mail: Nationwide Retirement Solutions
PO Box 182797
Columbus, OH 43218-2797

Fax: 877-677-4329