Seattle

The City of Seattle
Voluntary Deferred Compensation Plan
457(b) Unforeseeable Emergency Distribution Form

Personal Information

Plan Name: City of Seattle Voluntary Deferred Compensation Plan and Trust	Plan ID: 0056120001
Name:	SSN:
Date of Birth:	Gender: ☐ Male ☐ Female
Address:	
City, State, & ZIP:	Phone Number:
Email Address:	
How would you like to be contacted if additional information is required? ☐ Telephone ☐ Email	

Amount of Unforeseeable Emergency Withdrawal Request

Distributions due to unforeseeable emergencies are only permitted in the amount necessary to satisfy the financial need after reimbursement by insurance or other sources. Please attach required documentation to support the requested amount. This distribution may be taxable.

Amount Requested $ _____ **OR** ☐ Maximum Amount Allowed

Stopping your deferrals may help alleviate your financial need. If you would like to stop your deferrals please contact customer service at 855-550-1757.

NOTE: If you elect to discontinue your deferrals at this time, it will be your responsibility to re-enroll and begin your contributions when you are ready to resume deferral deductions.

Unforeseeable Emergency Details (Required)

Was the severe financial hardship a result of some unforeseeable circumstance arising as a result of events beyond the control of you, your spouse, dependent or primary beneficiary?

☐ **Yes** ☐ **No** (If no, **STOP**, do not submit your request. It does not qualify as an unforeseeable emergency.)

If yes, please provide a detailed explanation of the unforeseeable emergency that has caused you, your spouse, your dependent or your primary beneficiary a severe and unforeseeable financial hardship. Please be as detailed as you can, including names and dates.

Attach extra sheets if needed.

Date(s) unforeseeable emergency occurred _____

NOTE: Circumstances over 12 months from the date of application will not be considered for unforeseeable emergency distributions. **You will also need to complete and submit the Attachments for 457(b) Unforeseeable Emergency Distribution Form.**

Financial Position Acknowledgment

THIS ACKNOWLEDGMENT IS REQUIRED TO BEGIN THE REVIEW PROCESS

I attest that the unforeseeable emergency has caused a severe and unforeseeable financial hardship to me, my spouse, dependent, or primary beneficiary that cannot be met through any other means, including the following:

1. The reasonable liquidation of funds in checking and/or savings accounts, provided the liquidation would not itself cause an immediate and heavy financial need,
2. The reasonable liquidation of funds in investment accounts, IRA's, and/or insurance policy cash values, provided the liquidation would not itself cause an immediate and heavy financial need,
3. The reasonable liquidation of nonessential assets (i.e. rental/vacation properties, RV's, boats, or other), provided the liquidation would not itself cause an immediate and heavy financial need,
4. The cancellation of elective deferrals under the 457 Deferred Compensation Plan,
5. Other currently available distributions or nontaxable loans from other plans maintained by my employer or any other employer,
6. Borrowing from commercial sources on reasonable commercial terms in an amount sufficient to satisfy the need.
7. I certify that all of the information provided in this application is true, complete and accurate.

Print Name:	
Signature:	**Date:**

Unforeseeable Emergency Checklist

Please select the reason for an unforeseeable emergency distribution. Please see the examples below for documentation that may be required. The determination of whether or not your event is an unforeseeable emergency will depend on the facts and circumstances of the case. The Plan Committee has the ultimate authority to permit a distribution in an amount reasonably needed to meet the unforeseeable emergency. **You must submit documentation to support your request**

Reason	Supporting Documentation
☐ **Illness or Accident: Medical Expenses** (Not covered by insurance or other reimbursements)	☐ If you have health insurance: Explanation of Benefits statement from within the past 12 months from the insurance company indicating insurance coverage (or reasons for no coverage), patient responsibility and dates of service for all charges. ☐ If you do not have health insurance: include a signed statement indicating that you do not have insurance and the specific dates of no coverage. ☐ If you do not have insurance: Detailed bills indicating the medical provider's name & address, date of service, procedures performed and charges incurred within past 12 months. ☐ If medical expenses are for a dependent, include a copy of the most recent Federal Income Tax Return (pages 1 & 2 only) for you, and if married, your spouse. State tax forms are not needed. ☐ If the procedure could be considered cosmetic, a letter from a medical doctor/dentist indicating the reasons why the procedure is medically necessary. ☐ Copy of the Pre-Determination of Benefits, dated or issued within last 60 days, from the insurance provider. A statement from provider showing that payment must be made before treatment will be rendered. ☐ If you have a discounted Dental Plan that does not issue Dental Explanation of Benefits statements, please provide copies of the Schedule of Benefits that include the procedure code(s) that match the procedures on the dental pre-treatment estimate. ☐ Detailed prescription drug history from your pharmacy or insurance company stating dates medications were filled, how much insurance covered, and the dollar amount you are responsible for paying.
☐ **Illness or Accident: Loss of Income**	☐ Letter from your spouse's, primary beneficiary's, or dependent's employer indicating dates of employment and the dates of work missed that there was reduced or no pay received. This must also indicate any sick/vacation pay, disability pay, worker's compensation benefits, or any other form of compensation received while out of work. ☐ A Loss of Income Verification Form completed by your employer. ☐ A copy of the most recent Federal Income Tax Return (pages 1 & 2 only) for you, and if married, your spouse. State tax forms are not needed. ☐ A copy of the two most recent pay stubs for you, and if married, your spouse. ☐ Documentation from the Worker's Compensation board or disability board regarding your, your spouse's, primary beneficiary's, or dependent's Worker's Compensation or disability benefits. The documentation must state the date the benefits began/will begin, the amount of the benefits, and the date benefits will/may end. ☐ If your spouse, dependent, or primary beneficiary is self employed, letter from licensed physician indicating dates when the person was medically unable to work, and 1 year profit/loss statement and Schedule C tax filings.

Unforeseeable Emergency Checklist (continued)

Reason	Supporting Documentation
☐ **Property Loss Due To Casualty**	☐ If you have insurance: a letter from your insurance company indicating the amount covered by insurance and deductible amount owed, or reasons for no coverage. ☐ If you do not have casualty insurance: include a signed statement indicating that you do not have insurance and the specific dates of no coverage. ☐ Detailed repair estimate from a licensed contractor or licensed mechanic indicating the specific causes of the damage to your primary residence or primary vehicle. ☐ Police report. ☐ Letter from the other driver's insurance company stating why they are not covering the damages to your primary vehicle or the amount they will cover. ☐ A statement from your automobile lender indicating the amount still owed after the insurance payoff was received.
☐ **Medical/Dental/ Prescription Expenses**	☐ If the participant has insurance: Explanation of Benefits forms from the insurance company indicating insurance coverage (or reasons for no coverage), patient responsibility, and dates of service for all charges. ☐ If the participant does not have insurance: Detailed bills indicating dates of service for all charges and a signed statement indicating that the participant does not have insurance. ☐ If the procedure could be considered cosmetic, a letter from a medical doctor/dentist indicating the reasons why the procedure is medically necessary.
☐ **Funeral Expenses**	☐ A copy of the death certificate. ☐ Documentation of the relationship to the deceased. ☐ Detailed invoice from a funeral home and or cemetery that itemizes costs of funeral/burial expenses in which you are personally responsible, along with the amount that the decedent's funeral insurance/burial insurance will cover. ☐ If you are not listed as the responsible party on the bill, include a statement on or with the application indicating that you are responsible for the expenses. ☐ Copies of receipts, booking information (air/hotel), and other travel expenses related to the funeral and or burial.
☐ **Foreclosure / Eviction** (If requested more than once in a 24 month period, could be subject to additional review)	☐ Address on file matches the address on the request. If not, pages 1-2 of the 1040 Federal Tax Return and Schedule E (rental property page) are required (you may black out information that is not necessary to verify the address). ☐ Letter from the Mortgage Company or lender's attorney issued from within the past 30 days indicating a dollar amount needed to prevent imminent foreclosure, a clear future date due, and full address of property that is under threat of foreclosure. ☐ Eviction: A letter from the Leasing Agency or a copy of the Court Order Eviction issued within the past 30 days stating the dollar amount needed to prevent the eviction from your primary residence with the property address that is under threat of eviction. ☐ Copy of your current lease agreement. ☐ If a bankruptcy has been filed, documentation showing the mortgage lender has been granted relief from automatic stay or court order stating dismissal of bankruptcy case.
☐ **Extraordinary/ Unforeseeable Circumstance**	☐ Include copies of documents supporting your statement that the circumstances arose as a result of events beyond the control of you, your spouse, your dependent, or beneficiary.

Payment Method

Select One:

☐ ACH Instructions on File – Send funds to my bank account that Nationwide has on file.

☐ Send check by first class mail to my address of record. Allow 5 to 10 business days from process date for delivery. (Default option, if no other option is selected)

☐ I authorize NRS to send my payout check to me via overnight check to address of record for a fee of $25 (We will deduct the $25 from your account. Please also note, we can't offer overnight delivery to a PO Box and Saturday delivery may not be available in your area). Allow 2 to 4 business days from process date for delivery.

☐ New Direct Deposit ACH (complete information below)

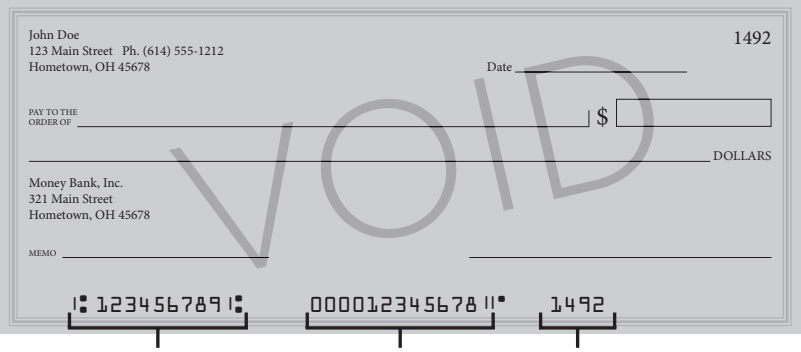
Financial Institution Information:

Financial Institution

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

Transit/ABA routing Number

Account 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.

Tax Withholding

Federal Tax: Please select one option, if no option is selected, NRS will use a default rate of 10% federal tax withholding.

☐ Increases the distribution amount to accommodate federal tax withholding on the taxable portion on my distribution. I will receive the approved amount of my request (by check or direct deposit), and the total distribution amount will be increased to include federal tax withholdings. NRS will use a default withholding rate of 10%. If account balance is insufficient to accommodate federal taxes, 100% of the account balance will be processed an 10% federal taxes will be withheld. The remaining balance will be sent (by check or direct deposit) to the member.

☐ Do not withhold federal tax from my distribution. I will be liable for all federal taxes that may result from this distribution.

State Tax: State 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 web site, NRS does not supply these forms.

Certification

Under penalties of perjury, I certify that:

1. The number shown 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 by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS 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.
4. The FATCA code entered on this form (if any) indicating that the payee is exempt from FATCA reporting is correct.

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

Authorization

I consent to a distribution as elected above. I understand that the terms of the Plan document will control the amount and timing of any payment from the plan. I further acknowledge that this distribution is not eligible for rollover to another retirement plan or IRA.

As required by law, and under the penalty of perjury, I certify the Social Security Number (Taxpayer Identification Number) and information I have provided is correct.

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

Print Name:	
Signature:	**Date:**

Form Return

By mail:

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

By fax: 877-677-4329

Express mail address:

Nationwide Retirement Solutions
3400 Southpark Place, Suite A
DSPF-F2
Grove City, OH 43123-4856

Seattle

The City of Seattle
Voluntary Deferred Compensation Plan
Attachments Unforeseen Emergency

This form must be completed and all supporting documents verifying both income and expenses must be attached.

Assets

	Current Value
Cash (Checking & Savings)	$ _____
Stocks & Bonds	$ _____
Life Insurance Cash Value	$ _____
IRA	$ _____
Total Assets	**$** _____

Current Monthly Income

Your Gross Salary per month	$ _____
Spouse's Gross Salary per month	$ _____
Other Household Income	$ _____
Taxes Withheld	$ _____
Other Deductions	$ _____
Total Deductions	$ _____
Total Net Income	**$** _____

Current Monthly Expenses

Home Mortgage, Payment or Rent	$ _____
Utilities (Electric, Heat, Water, Tele, etc)	$ _____
Food	$ _____
Clothing	$ _____
Medical Expenses	$ _____
Car Payments	$ _____
Other Transportation Expenses	$ _____
College Expenses	$ _____
Insurance Premiums (Life, Health, Home, Car, etc.)	$ _____
Other (List):	
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
Total Current Expenses	**$** _____