



**403(b) PLAN
CO-784 DISTRIBUTION ELECTION
ELIGIBILITY APPLICATION**
REV. 02/2011 www.CTdcp.com

MAIL COMPLETED FORM TO:

**STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**
55 ELM STREET
HARTFORD, CT 06106-1775
TELEPHONE: 860-702-3543
www.osc.state.ct.us

Read the reverse side of this form, the applicable Plan document and the Special Tax Notice carefully before completing this application. All sections must be fully completed. Please type or print clearly in ink. The Office of the State Comptroller must approve all requests. You may not alter any of the printed information on this document. If you make a mistake, you must complete a new form.

Participant Information Please Print	Name & Address of Employing Agency		Social Security Number	Department ID
	Participant (last, first, middle initial)	Former name (if applicable)	Employee Number	Employee Record Number
	Street Address		Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth
	City, State, Zip Code		Office Telephone No.	Home Telephone No.

Financial Services Organization Contact Information	Financial Services Organization Name (Complete a separate application for each Financial Services Organization you utilize)		
	Mailing Address		
	City, State, Zip Code		
	Contact Number	Fax Number	

Reason for Distribution	<input type="checkbox"/>	SEPARATION FROM STATE SERVICE	DATE:
	<input type="checkbox"/>	RETIREMENT	DATE:
	<input type="checkbox"/>	DISABILITY RETIREMENT	DATE:
	<input type="checkbox"/>	DEATH (Beneficiary must sign this form)	DATE:

I hereby request that the State of Connecticut verify my eligibility for a distribution from the 403(b) Plan pursuant to the status indicated above. I understand that by signing this application: (1) the Financial Services Organization may require me to submit additional paperwork to complete the distribution process, (2) once benefits payable as an annuity have commenced, they cannot be modified, (3) benefits not payable as an annuity may be changed at any time, (4) distributions from this plan may be included in my taxable income and subject to withholding in accordance with Internal Revenue Service rules. I acknowledge that I have read and understand the instructions, terms and conditions on the reverse side of this application, the applicable Plan document and the Special Tax Notice.

Participant or Beneficiary Signature	Date:	Office of the State Comptroller (Authorized Signature/Date)
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OFFICIAL USE ONLY	
VERIFIED BY	DATE:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED

REMARKS:



**MAIL THE ORIGINAL SIGNED FORM TO THE ADDRESS INDICATED AT THE TOP OF THIS FORM
MAKE A COPY FOR YOUR RECORDS**

Authorization	<p>This form, upon approval by the Office of the State Comptroller, authorizes your Financial Services Organization (FSO) to begin making benefit payments to you.</p> <p>Once approved, the Office of the State Comptroller will notify the selected FSO. Your FSO may require you to submit additional paperwork to complete the distribution process. Subsequent distribution requests may be submitted directly to your FSO without further approval from the Office of the State Comptroller. For additional information, contact your FSO.</p> <p>The special Tax Notice regarding plan payments is available online at: http://www.osc.state.ct.us/empret</p> <p>The Plan document is available from your FSO or online at: http://www.osc.state.ct.us/empret</p> <p>The effective data of distribution is contingent upon the Office of the State Comptroller's processing requirements, the FSO's processing requirements and the provisions of Section 403(b) of the Internal Revenue Code as outlined in the Special Tax Notice.</p> <p>This form may not be used to request permitted in-service withdrawals under the Plan. To apply for benefit payments/withdrawals or a financial hardship withdrawal, contact the Third Party Administrator Service Center at 1-800-584-6001.</p>
Financial Services Organization Contact Information	<p>Complete the FSO contact information. You must complete a separate application for each FSO from which you seek a distribution.</p>
Reason for Distribution	<p>Check the appropriate box and indicate the date of the event. If the distribution is due to the death of a Participant, the Beneficiary must sign this form and attach the original or certified copy of the Participant's death certificate.</p>
Additional Information	<p>The distribution options are subject to the terms of the Plan document governing your State of Connecticut Defined Contribution Plan. With the exception of annuity payments, you may be able to change your distribution options after payments begin. For more information concerning distribution options, eligible rollovers, payment options available to beneficiaries or the tax implications of your election, contact your FSO.</p> <p>Payment made directly to the Participant or the Beneficiary is taxable and subject to Federal Income Tax Withholding at the time of distribution. For states that impose a State Income Tax, payment made directly to the Participant or Beneficiary is taxable and subject to State Income Tax Withholding as income at the time of distribution. Note that if you take a distribution before age 59 1/2, a 10% additional penalty may apply.</p> <p>Certain distributions are eligible for rollover into another eligible retirement plan or IRA. If you select a direct rollover distribution, your payment will not be taxed and no income tax will be withheld. If you choose to have a Plan payment that is eligible for rollover paid to you, the FSO is required to withhold a 20% of that amount and pay it to the Internal Revenue Service as income tax withholding.</p> <p>Distributions that are not eligible to be rolled over include those payable (a) as life annuity or joint and survivor annuity, (b) in installments expected to last ten years or more, (c) as part of the age 70 1/2 required minimum distribution, or (d) due to an unforeseen emergency or hardship withdrawal. The amount of any distribution that is not eligible for rollover is subject to 10% withholding in the year received, unless you elect otherwise.</p> <p>For further information concerning the tax liabilities arising out of your participation in the 403(b) Program contact your FSO, the IRS, your local tax authorities and/or, your own tax/financial advisor.</p>
Participant Signature	<p>Your signature acknowledges agreement to the terms, provisions and conditions of the State of Connecticut 403(b) Plan for Eligible Employees; which terms, provisions and conditions are hereby incorporated into this Distribution Election Eligibility Application and constitute your entire rights and obligations under the Plan. You understand and acknowledge that all Plan assets shall be held in trust by the trustee appointed by the Comptroller for the exclusive benefit of the Participant and Beneficiary in accordance with the Plan and the Internal Revenue Code. You understand that participation in the State of Connecticut 403(b) Plan for Eligible Employees is voluntary. In return, you, your heirs, successors and assignees shall hold harmless the State of Connecticut and its employees, officials, agents, assignees and successors from any and all liability for all acts in good faith.</p>
	<p>Keep a copy of this Application for your records. Return the original signed form to the address shown on the front of this form.</p>

