

EMPLOYEE TERMINATION REQUEST

DEFINED BENEFIT RETIREMENT PLAN

TYPE OF BENEFIT REQUESTING			
<input type="checkbox"/> Actual benefit calculation requested (check reason for leaving below): <input type="checkbox"/> Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Total and Permanent Disability <input type="checkbox"/> Death (include copy of death certificate) <input type="checkbox"/> Use online Beneficiary Election for the death benefit. (If this box is not selected, please attach most recent beneficiary designation form.) <input type="checkbox"/> Estimated benefit calculation requested (submit a separate form for each estimated date or estimated age)			
EMPLOYER INFORMATION			
Employer Name _____			
State	Employer Contract Number (8 digit) _____	Plan Number <input type="checkbox"/> 001 <input type="checkbox"/> 002 <input type="checkbox"/> 022 <input type="checkbox"/> Other _____	
EMPLOYEE INFORMATION			
Employee Name _____	Date of Birth / /	Social Security Number - -	Termination Date / /
Home Address Street _____	City _____	State _____	Zip _____
Rehire Date (if applicable) / /	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Spouse's Name _____	Spouse's Date of Birth / /
Phone Number (optional) () _____			
HOURS OF SERVICE (for Vesting)			
Enter the following dates. Then, determine if the employee worked more or less than 1,000 hours during these time frames:			
		<u>Under 500 hours</u>	<u>500-999 hours</u>
_____ Hire Date	Through _____ Plan Anniversary Following Hire Date	<input type="checkbox"/>	<input type="checkbox"/>
_____ Last Plan Anniversary Date	Through _____ Termination Date	<input type="checkbox"/>	<input type="checkbox"/>
These hours should include paid vacation and sick leave up to 501 hours. We will assume the employee worked 1,000 hours or more in each full plan year between the above dates unless otherwise noted on a separate sheet attached to this form.			
SALARY			
Enter the total includable compensation* earned during the highest consecutive 60 (or 36) months of service as defined in your plan.			
	<u>60 months</u>	<u>36 months</u>	
Compensation from ____/____/____ through ____/____/____	(_____ months)	(_____ months)	\$ _____
Compensation for the entire plan year of _____	(12 months)	(12 months)	\$ _____
Compensation for the entire plan year of _____	(12 months)	(12 months)	\$ _____
Compensation for the entire plan year of _____	(12 months)		\$ _____
Compensation for the entire plan year of _____	(12 months)		\$ _____
Compensation from ____/____/____ through ____/____/____	(_____ months)	(_____ months)	\$ _____
*Please refer to the definition of compensation in your Plan document.			
EMPLOYEE CONTRIBUTIONS (if applicable)			
Enter contributions made by employee from last plan anniversary date to date of termination: • Employee Contributions: \$ _____			
PLAN ADMINISTRATOR SIGNATURE	RETURN TO		
I, as Plan Administrator, verify that the above information is correct. Signature: X	Date _____	ATTN Retirement Plan Services CUNA Mutual Group PO Box 2978 Madison WI 53701-2978	