

## Full Distribution Request

**Use this form to request:** A distribution of a participant's entire vested account balance due to retirement, disability, termination from employment, attainment of age 59.5 or 70.5, or to purchase an annuity from all qualified retirement plans.

American United Life Insurance Company®  
a ONEAMERICA® financial partner  
One American Square, P.O. Box 6011  
Indianapolis, IN 46206-6011  
1-800-249-6269



### A. To Be Completed By You – Plan Information as it Appears on Your Quarterly Statement

Plan Number: \_\_\_\_\_ Plan Name: \_\_\_\_\_

### B. To Be Completed By You – Information About You

Your Name: \_\_\_\_\_ Your E-mail Address: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Your Mailing Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

Daytime Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Evening Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### C. To Be Completed By You – Payment Information

- I elect a payment of my vested account balance to be sent to me. **\*Proceed to Section E.**
- I elect a direct rollover of my vested account balance. **\*Complete Section D.**
- I elect a direct rollover of \$\_\_\_\_\_ with any remainder paid to me. **\*Complete Section D.**
- I elect a payment of \$\_\_\_\_\_ with any remainder paid as a direct rollover. **\*Complete Section D.**
- I elect to purchase an annuity with my entire vested account balance. **\*Complete and attach the Annuity Request Form.**

**If you do not select a box above, a payment of your entire vested account balance will be sent to you.**

### D. To Be Completed By You – For Rollovers Only: Where Would You Like Your Payment Sent?

#### Rollover to:

- AUL IRA AUL IRA Account Number: \_\_\_\_\_ – **If account number is left blank, an AUL representative will contact you regarding your request. A minimum account balance of \$5,000 is required to open an AUL IRA.**
- Another financial institution. Please provide the financial institution information below:

Name of financial institution to which check should be made payable:

Account #: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

### E. To Be Completed By You – Your Approval

I certify that I received the Special Tax Notice and the information provided in Sections A., B., C., and D. is complete and accurate to the best of my knowledge. If applicable, I certify that the qualified retirement plan or IRA named to receive my payment(s) is an eligible plan for purposes of receiving direct rollovers. I understand that state taxes will only be withheld if I reside in a state that requires withholding.

I understand that a change in my employee status may impact disability benefits under the terms of my plan.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

– Page 2 must be completed by Employer –

**F. To Be Completed By Your Employer – Reason For Distribution**

Termination of Employment: \_\_\_\_/\_\_\_\_/\_\_\_\_ *Please select one option below.*

1. This distribution qualifies as the following type of benefit:

- |  |  |
|--|--|
| <input type="checkbox"/> Early Retirement benefit  | <input type="checkbox"/> Termination benefit |
| <input type="checkbox"/> Normal Retirement benefit | <input type="checkbox"/> 59.5 benefit        |
| <input type="checkbox"/> Disability benefit        | <input type="checkbox"/> 70.5 benefit        |

*If you do not check a box above, "Termination benefit" will be assumed.*

**G. To Be Completed By Your Employer – Additional Information**

1. Hours worked in the year of termination.

Hours worked\*: \_\_\_\_\_ hours *\*If no hours are reported, a full year of service will be assumed.*

2. The participant's vested percentage is\*: \_\_\_\_\_%

*\*If left blank, your signature authorizes using the vesting calculated by the recordkeeping system.*

3.  Yes  No The participant wants to wait 30 days before the benefit is paid out?  
If no option is selected, the benefit will be paid immediately.

4. Does the participant have an outstanding loan(s)?

If yes, please enter the date of default: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy).

**H. To Be Completed By Your Employer – Employer Approval**

I certify that the information provided above is complete and accurate to the best of my knowledge and the request complies with the provisions of the plan. **The Special Tax Notice was provided to the participant. The Spousal Consent, if applicable, has been properly completed and remains in the Employer Designated Representative's records.** American United Life Insurance Company® is hereby directed to make benefit payment as elected above.

Please send check to Employer Designated Representative. Otherwise, check will be mailed directly to the participant for payments or financial institution for rollovers.

\_\_\_\_\_  
**Employer Designated Representative Signature**

\_\_\_\_\_  
**Date:**