

DISTRIBUTION REQUEST FORM FOR SEPARATION OF EMPLOYMENT

Plan Name:

Please Print

Participant Name: \_\_\_\_\_

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

Street

\_\_\_\_\_

City

State

Zip

Date of Birth: \_\_\_\_\_

Date of Hire \_\_\_\_\_

Social Security # \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_

Date of Separation from Employer: \_\_\_\_\_

Due to:

\_\_\_\_ Termination of Employment

\_\_\_\_ Retirement

\_\_\_\_ Death

Hours Worked in Plan Year of Separation: \_\_\_\_\_

Date \_\_\_\_\_

Trustee Signature \_\_\_\_\_

**Fax to Omega, Inc., 315-449-4148**