SATURNA TRUST COMPANY

401(k) Distribution Election Form

All requests must be accompanied by a signature. If you have any questions or concerns regarding this form, please call us at **833-STC-401K** (833-782-4015).

Mail or fax completed forms to:

Saturna Trust Company
P.O. Box 100
Bellingham, WA 98227-0596
F: 360-734-0755

Section 1. Employee Information

Full Legal Name

Preferred Salutation *(optional)*: ◯ Mr. ◉ Mrs. ◯ Ms. ◯ Dr.

Physical / Street Address *(Required - P.O. boxes are not accepted)*

City | State | Zip

Preferred Phone *(or best number to call)*

Last 4 digits of Social Security Number

Email:

Section 2. Employer Information

Name of Business / 401(k) Plan

401(k) Registration Number

Section 3. Reason for Distribution

- ◯ Termination of Employment: Date of Termination
- ◯ Retirement
- ◯ Total Disability *(Please attached proof of disability)*
- ◯ In Service (over 59 1/2) if Plan allows
- ◯ Death *(Please attach certified death certificate & letters of testament)*
- ◯ Qualified Domestic Relations Order (QDRO - *Please attach copy*)
- ◯ ADP/ACP Correction
- ◯ Plan Termination
- ◯ Required Minimum Distribution *(Please see Special Tax Notice Regarding Plan Payments)*

Section 4. Distribution Election *Please see the Special Tax Notice Regarding Plan Payments*

- ◯ Direct Trustee to Trustee Rollover of entire vested account balance.* *(Proceed to Section 5)*
- ◯ Please mail me a check for: *(choose one of the following options)*
  - ◯ My entire vested account balance.*
  - ◉ The following dollar amount(s) or percentage(s) of my vested account balance.
    - ◯ **Regular 401(k):** $ _____ or _____ %
    - ◉ **Roth 401(k):** $ _____ or _____ %

For fund-specific distributions, please attach a letter of instruction to this form.

** A fee of $60.00 will be withheld for rollover or distribution of total vested account balance.*

I understand a mandatory 20% Federal Income Tax may be withheld from my distribution. An additional State Tax percentage may also be withheld. *(Note: Distributions may be subject to a 10% penalty tax unless an exception applies.)*

Last Name

Last 4 digits of SSN

Section 5. Transfer/Rollover Information *(Complete only for Trustee to Trustee transfers)*

Name of New Trustee / Custodian Firm

Account Number (**Required**)

Trustee/Custodian Firm's Address

Trustee/Custodian Firm's Phone

City | State | Zip

Type of transfer

- ○ Direct Rollover to another Employer Plan—***Attach copy of most recent statement for your Employer Plan***

  Name of Employer Plan:
- ○ Direct Rollover to an IRA—***Attach copy of most recent statement for your existing IRA***
- ◉ Direct Rollover to an Roth IRA—***Attach copy of most recent statement for your existing Roth IRA***

Section 6. Loan Information

- ◉ N/A - I do not have an outstanding loan
- ○ I will NOT be paying off my loan. I understand the outstanding balance will be considered a distribution and that I will be responsible for associated taxes and penalties.
- ○ I would like to PAY OFF my loan. I have enclosed a check for the outstanding balance.

  (To obtain loan payoff information, please contact Saturna Trust Company at 1-360-650-6963. Your funds will not be distributed until the loan payoff is complete.)

Section 7. Signatures

Employee

I understand the terms and conditions relating to the payment of taxable benefits from the Plan as explained in the Special Tax Notice Regarding Plan Payments. I also understand that any securities holdings that I have in my account will be sold once I submit this form and I agree to this liquidation in order to process my distribution. I certify that the above information is true and correct to the best of my knowledge and that the Direct Trustee to Trustee Rollover or Employer Qualified Plan named in the Transfer section of this form is an "Eligible Rollover Distribution" as defined in Internal Revenue Code 401(a)(31)(D). I understand the Plan Administrator will rely on this information in making the distribution that I have requested. I hereby consent to the payment of my vested account balance. Furthermore, I elect to waive my 30-Day Election Period (see Special Tax Notice Regarding Plan Payments).

Employee Signature

Date

Employer

I certify the information given above is true and complete to the best of my knowledge. I understand the Employee's funds will be forwarded per the instructions directed by the Employee. In addition, I authorize the withdrawal and disbursement of this benefit according to the terms of this contract and The Plan. Please distribute the funds according to the instructions on this form.

Administrator Signature

Date