

APPLICATION FOR DEATH BENEFIT

Name of Deceased _____ Soc. Sec. No. _____

Name of Plan _____ Date of Death* _____

* Attach a copy of the certified medical certificate of death.

I hereby apply for death benefits, if any, payable in accordance with the provisions of the Retirement Plan. For the purpose of processing the Death Benefit, I submit the following:

Name of Applicant _____ Social Security No. _____

Address _____
STREET CITY STATE ZIP CODE

Phone No. () _____ Relationship to Deceased _____

Applicant's Date of Birth _____ (Include Proof of Age with photo ID)

Has the Deceased been employed by another Municipality? _____ If yes, where: _____

If applicant is the spouse and not legally separated from the deceased, provide:

Date of Marriage _____ (Include copy of Marriage Certificate)

DESIGNATE FORM OF PAYMENT: *(Skip this section if benefit is continuation of Joint & Survivor Option)*

Check one of the following:

- _____ SPOUSE'S MONTHLY PENSION PAYABLE FOR LIFE OR UNTIL REMARRIAGE
(Applicable for a Death Benefit on a vested active participant not legally separated from the surviving spouse, or as a Death Benefit for a retiree who has not yet begun benefit payments.)
- _____ MONTHLY PENSION PAYABLE TO NON-SPOUSE FOR PERIOD CERTAIN
(Applicable for a Death Benefit on a vested participant, active or retired, who was not married and who had not yet begun benefit payments.)
- _____ CONTRIBUTION REFUND - Payable for Death Benefit on a Participant who was not vested.
- _____ LUMP SUM - If allowed in the plan, payable for Death Benefits on Participants who were:
 1. Active and Vested but not married; or
 2. Retired and within the Period Certain (guaranteed number of payments) and did not elect a Joint & Survivor Option.

I hereby certify and warrant that, to the best of my knowledge and belief, the foregoing information is true and correct and that no material fact has been concealed or omitted.

NOTE: Applicant must complete and sign both sides of this form in order to receive payment.

Name _____ Date _____
Signature of Applicant

1. I have confirmed the applicant is the **designated beneficiary** for the Deceased participant named above.
2. The above-named applicant has received a copy of the **Special Tax Notice** regarding plan payments.
3. The above-named applicant is **approved**.

_____ BY: _____
Date Authorized Agent for the Retirement Committee

MUST BE COMPLETED BY EMPLOYER BEFORE BEING SUBMITTED TO OMRF:

Deceased's Hire Date _____ Deceased's Date of Birth _____
Status: () Terminated. If so, provide Date of Termination: _____
() Active. If so, provide the final payroll contribution \$ _____ for payroll ending _____



TAX WITHHOLDING ELECTION
Federal and State Income Tax Withholding

Name _____ Social Security No. _____

COMPLETE SECTION "A" OR "B" BELOW: Name of Plan _____

Section A. RECURRING PAYMENTS – Federal and State Income Tax Withholding

Instructions: As a benefit recipient, the following withholding alternatives are available to you:

- By selecting No. 1 below, you may specify that you do not want any federal or state income tax deducted from your benefit .
- By selecting No 2 below, you may elect the "Allowances Claimed" section and completing the marital status and number of allowances which will require the OkMRF system to determine the amount, **if any**, which must be withheld based on federal and state withholding tables. If elected, the tax withholdings may or may not meet your required amounts.
- By selecting No. 3 below, you may elect to withhold a specified percentage or amount for federal and state income taxes.

In requesting the distribution of my funds from OkMRF, I designate the following withholding election. This election will remain in effect until I submit another.

1. _____ I elect **not** to have Federal or State income tax withheld.
2. _____ I wish to have OkMRF withhold from my monthly benefit the amount of federal and state income tax as determined in accordance with withholding tax tables and the allowances claimed below:
 Single Married Married –but withhold at higher Single Rate
_____ Number of withholding allowances/exemptions you want to claim.
3. a. _____ I wish to have _____ (% or \$ amount) of Federal income tax withheld.
b. _____ I wish to have _____ (% or \$ amount) of State income tax withheld.

If you do not file a Tax Withholding Election form with OkMRF, we are required by law to assume that you are married and are claiming 3 (three) allowances. We will automatically withhold federal and state income tax if your payment is large enough to require withholdings.

Section B. ONE-TIME PAYMENTS – Federal and State Income Tax Withholding

Instructions: When receiving a total distribution from OkMRF, you may receive the payment in one of two methods:

- The distribution can be made payable to you directly, in which case a mandatory 20% Federal tax withholding and 5% Oklahoma state tax withholding will occur. (The mandatory tax withholding only applies to the taxable portion of your distribution.) **OR**
- You can direct OkMRF to roll over the distribution into an IRA or other qualified plan without taxes being withheld. *You will receive the non-taxable portion of the distribution payable to you even if you direct the taxable portion to a qualified plan or IRA. Rollover checks will be payable to the rollover entity "For the Benefit of" and then your name. All distributions are mailed directly to your address of record.*

In requesting the distribution of my funds from OkMRF, I designate the following method of payment:

1. _____ **I WANT THE CHECK(S) MADE PAYABLE TO ME. I am aware of the mandatory 20% Federal and 5% Oklahoma withholding * on the taxable portion of my distribution.**
*(Withholding rate is 5% and is subject to change based on Oklahoma State withholding tables.)
If you've made a permanent move into a new state during the tax year, you may have to file two part-year state tax returns.
You may wish to consult with a professional tax advisor, before taking a payment from the Plan.
2. _____ I WANT A DIRECT ROLLOVER TO A **TRADITIONAL IRA.** (YOU MUST SUBMIT A COPY OF YOUR IRA AGREEMENT FOR A DIRECT ROLLOVER.)
3. _____ I WANT A DIRECT ROLLOVER TO A **QUALIFIED PLAN.** (YOU MUST SUBMIT A COPY A RECENT PARTICIPANT STATEMENT AND THE PLAN'S CONTACT INFORMATION)

I have reviewed the information above and hereby submit this statement of preference regarding how my benefit distribution is to be treated for purposes of federal and state income tax withholding.

Date

Participant's Signature