Election of Benefits

(For a Participant) Single Sum Payment, Lump Sum Payment or Rollover Bundled/Full Service

Return via Mail or Fax:
AXA Equitable
PO Box 8095
Boston, MA 02266-8095

Fax Number:
(816) 218-0412

For Assistance:
Call (800) 528-0204
www.axa.com

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PLEASE PRINT

We will process the withdrawal request on the business day we receive a properly completed form. ***Failure to properly complete this form will cause a delay in payment.***

1. Participant Information

First Name, Middle Initial _____ Last Name _____ Social Security Number _____

Address (to which payments and/or future mailings are to be sent) _____ City _____ State _____ Zip Code _____

Daytime Telephone Number _____ Mobile Phone Number _____ Email Address _____

Employer's Name _____ Contract ID Number _____

Employer's Contact Telephone Number _____

2. Benefit Election & Forms of Benefit

The Election of Benefits is submitted because the participant is: (*To be completed by the Employer/Plan Administrator)* ***(check one)***

- ☐ No longer employed by this employer and/or past Normal Retirement Age; (date no longer employed ___/___/___) mm dd yyyy
- ☐ Disabled. *(Attach Notice of Disability);* (date no longer employed ___/___/___) mm dd yyyy
- ☐ Still employed, 100% vested and between age 59½ and Normal Retirement Age (Profit Sharing Only);
- ☐ Plan Termination *(Attach Notice of Termination from Employer);*
- ☐ Retirement; (date no longer employed ___/___/___) mm dd yyyy
- ☐ In-service Withdrawal.

I hereby elect the following form of benefit: *(To be completed by the Participant)* ***(Check one):***
(If you elect either a Single Sum Payment or Partial Payment, you will be paid directly and the payment may be subject to mandatory withholding and an additional 10% tax if you are under age 59½.)

- ☐ ***Single Sum Payment*** of the entire Retirement Account Value.
  Is the participant married? If yes, spousal consent may be required. ☐ Yes ☐ No
- ☐ ***Partial Payment*** in the amount of _____ (you may enter a dollar amount or a percentage).
  Funds are withdrawn on a pro-rata basis from each Investment Option. If you have monies in the PIB investment option, please refer to your Program Summary for information on how distributions can reduce your Ratchet Base and GAWA. ***Go to Page 2 to specify the investment option contribution sources.***

2. Benefit Election & Forms of Benefit (Continued)

Specify the contribution source(s) from which you wish to request your withdrawal (e.g., Salary Deferral, Employer Matching, etc.). Indicate a dollar amount or write "total" on the amount line for that Investment Option. (If you need additional space, attach a separate sheet showing the following information.)

Source	Investment Option	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

☐ ***Rollover*** to another qualified plan, 403(b), Governmental 457 Plan or IRA.

I want my distribution transferred to an IRA or another qualified plan, 403(b) or Governmental 457 Plan.

A. Dollar amount or percent being transferred _____

B. Check payable to (Bank, Financial Institution, Trustees, etc.) _____

C. Account Number (if available) _____

D. Address to which check is to be sent _____

_____

*** ONLY** for Roth IRA distributions not subject to 20% Mandatory Withholding:

☐ I elect to have _____ % Federal Income Tax withheld from my proceeds.

☐ I do not want Federal Income Tax (and state, if applicable) withheld from my proceeds.

Some states require us to withhold state income tax if federal income tax is withheld. Please consult your tax advisor for rules that apply to you.

3. Spousal Consent *(if applicable)*

Please note that the signatures below must be within 90 days of the date of distribution in order to be valid. Also, the date of the witness's signature must be the same as the date of the spouse's signature.

If this is a Money Purchase Plan or money has been rolled over from a Money Purchase Plan and the Participant is married, spousal consent witnessed by a Notary or Plan Representative is required before a distribution may occur; otherwise spousal consent is not required.

X _____	_____	_____
Signature of Spouse	Print Name of Spouse	Date (mm/dd/yyyy)
X _____	_____	_____
Witness by Plan Representative or Notary Public	Print Name of Plan Representative or Notary Public	Date (mm/dd/yyyy)

4. Signatures/Authorization

I understand the IRS regulations provide that I receive the Special Tax Notice no less than 30 days and no more than 90 days prior to my distribution. If I checked box A or B in Section 3, indicating that I do not want my distribution transferred to an IRA, qualified plan, 403(b) Plan or Governmental 457 Plan I acknowledge that the taxable amount of my distribution will be subject to a 20% federal tax-withholding rate. If I checked box C in Section 3, I understand that the vested portion will be transferred directly to my IRA, qualified plan, 403(b) Plan or Governmental 457 Plan. The qualified plan, 403(b) Plan or Governmental 457 Plan will accept this direct rollover. In addition, any remaining taxable portion may be subject to a 20% federal tax-withholding rate. I understand that there is a $25.00 fee per check issued.

Income Tax Withholding (to be completed by participant)

I understand that this distribution will be reported to the Internal Revenue Service and the state of my residence, if applicable, as taxable income as appropriate. The address on this form will determine my state of residence for state withholding purposes. I also understand that the distribution will be subject to income taxes, and that any distribution that is greater than $200 is subject to 20% mandatory federal income tax withholding unless I rollover the distribution amount to another retirement account. I further understand that if I receive this distribution prior to age 59½ the distribution may be subject to a 10% early withdrawal penalty.

I have read the "Special Tax Notice" provided to me by the Plan Administrator. I request payment from the Plan designated above as indicated.

☐ By checking this box, I am indicating that I wish to waive the 30-day notice period in order for my distribution to be processed immediately.

Any person who knowingly, and with an intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information may be guilty of a crime, which could result in imprisonment, fines, denial of insurance and civil damages.

The Participant and Plan Administrator certify that to their knowledge the information contained on this Form is correct.

X _____	_____	_____
Signature of Participant	Print Name of Participant	Date (mm/dd/yyyy)
X _____	_____	_____
Signature of Plan Administrator/Employer	Print Name of Plan Administrator/Employer	Date (mm/dd/yyyy)