RSA-1 SBD
03/16

SMALL BALANCE DISTRIBUTION
PEIRAF/RSA-1 DEFERRED COMPENSATION PLAN

Retirement Systems of Alabama
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Do not use this form if you are no longer publicly employed.

Name _____
First Middle/Maiden Last

Address _____ **Social Security No.** _____
Street or P. O. Box

_____ **Phone Number** _____
City State Zip Code

Notice: Full adherence by all parties to the Internal Revenue Code and Regulations governing Section 457 deferred compensation plans is required for the plan to remain eligible. If the plan is not operated in compliance with the Internal Revenue code and Regulations, the tax benefits of the plan can be denied to all participants in the plan. For this reason, the participant should carefully read the conditions governing the Small Balance Distribution.

The Internal Revenue Service allows a **one-time** special cash-out provision if **ALL** the following conditions are met:

1. The account balance is $5,000 or less,
2. There have been **no deferrals** into the account for 24 months prior to the small balance distribution, and
3. There have been **no prior distributions** other than hardship distributions.

I hereby make application for the full distribution of my deferred compensation fund under the one-time small balance distribution. Distributions are subject to federal and state income tax. I understand that once this small balance distribution has been used, it cannot be used again.

I understand I may not defer to this plan until after one full year from this small balance distribution.

Signature of Payroll Officer _____ **Date** _____

Signature of Member _____ **Date** _____

STATE OF_____, COUNTY OF _____

On this _____ day of _____, 20_____, personally appeared before me, the above-named _____ and made oath that the statements are true.

Signature of Notary Public _____

Seal My Commission Expires _____