



# DISTRIBUTION ELECTION COMMONWEALTH OF VIRGINIA VOLUNTEER FIREFIGHTERS' & RESCUE SQUAD WORKERS' SERVICE AWARD PROGRAM

## PART A. MEMBER INFORMATION

<b>2. Name</b> (First, Middle Initial, Last)		
<b>3. Address</b> (Street, City, State and ZIP+4)		
<b>4. Social Security Number</b>	<b>5. Date of Birth</b>	<b>6. Phone Number</b>
<b>7. Department/Squad Information</b> <input type="checkbox"/> Fire <input type="checkbox"/> Rescue      Department/Squad Name: _____ Location/County: _____ Total years of service (full years only, no additional months): _____ yrs		

## PART B. DISTRIBUTION SELECTION - Check appropriate box(es)

<input type="checkbox"/> <b>Member under age 60 withdrawing from the VOLSAP Fund and requesting distribution.</b> I am entitled to my contributions minus investment losses and an administrative fee of \$25. Members under age 60 do not receive State or Department/Squad contributions.						
<input type="checkbox"/> <b>Member age 60 or older, served less than five years as an eligible volunteer.</b> I am entitled to a lump-sum distribution equal to the amount of my contributions, plus or minus investment gains or losses.						
<input type="checkbox"/> <b>Member age 60 or older, served between five and 10 years as an eligible volunteer.</b> I am entitled to a lump-sum distribution equal to the amount of my contributions, any contributions made on my behalf by my Department/Squad and the percentage as checked below of any contributions that may have been made by the State, plus or minus investment gains or losses on all contributions. <table style="width: 100%; margin-top: 5px;"><tr><td style="width: 50%;"><input type="checkbox"/> End of year 5, 5% of State contributions</td><td style="width: 50%;"><input type="checkbox"/> End of year 8, 45% of State contributions</td></tr><tr><td><input type="checkbox"/> End of year 6, 10% of State contributions</td><td><input type="checkbox"/> End of year 9, 70% of State contributions</td></tr><tr><td><input type="checkbox"/> End of year 7, 25% of State contributions</td><td><input type="checkbox"/> End of year 10 or beyond, 100% of State contributions</td></tr></table>	<input type="checkbox"/> End of year 5, 5% of State contributions	<input type="checkbox"/> End of year 8, 45% of State contributions	<input type="checkbox"/> End of year 6, 10% of State contributions	<input type="checkbox"/> End of year 9, 70% of State contributions	<input type="checkbox"/> End of year 7, 25% of State contributions	<input type="checkbox"/> End of year 10 or beyond, 100% of State contributions
<input type="checkbox"/> End of year 5, 5% of State contributions	<input type="checkbox"/> End of year 8, 45% of State contributions					
<input type="checkbox"/> End of year 6, 10% of State contributions	<input type="checkbox"/> End of year 9, 70% of State contributions					
<input type="checkbox"/> End of year 7, 25% of State contributions	<input type="checkbox"/> End of year 10 or beyond, 100% of State contributions					
<input type="checkbox"/> <b>Beneficiary.</b> As a beneficiary, I am entitled to a lump-sum distribution of the full value of the account of the member name above in Part A.						

## PART C. MEMBER/BENEFICIARY CERTIFICATION

I certify I am entitled to a distribution from my account as indicated above. I understand no taxes are due on contributions made by me. Contributions made by the State or my Department/Squad as well as earnings on all contributions are taxable and will be reported to the IRS on Form 1099. Distributions will be made within 60 days of the close of the plan year, June 30.	
_____ Member/Beneficiary Signature	_____ Date
_____ Beneficiary Printed Name	_____ Beneficiary SSN
<input type="checkbox"/> Check this box if you are the beneficiary, sign above and attach a copy of the death certificate. (Before submitting the form to the department/squad, complete Part A with the member's information and check this box, then sign and date the form above.)	

## PART D. DEPARTMENT/SQUAD CERTIFICATION

<input type="checkbox"/> I certify the above-named applicant is eligible for a distribution of his or her account as requested above.	
<input type="checkbox"/> I certify that the applicant is the beneficiary (if appropriate box checked in the Member/Beneficiary Certification).	
_____ Authorized Signer's Printed Name	_____ Date
_____ Authorized Signer's Title	_____ Daytime Phone Number
_____ Authorized Signature	

Send completed form to:

**Principal Custody Solutions/VOLSAP  
510 N. Valley Mills Dr., Suite 400  
Waco, TX 76710**

Email questions to:  
**volsap@usi.com**