Trust Company of America

Distribution Form
Carolina Meadows, Inc. 403(b) Plan

Section 1
Participant Information

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

_____ _____ _____ _____
Street Address City State Zip Code

(_____)_____ _____ _____
Home Phone Date of Birth Last Day of Employment

Section 2
Distribution Election

I have received, read and understand the "Special Tax Notice Regarding Plan Payments" containing general information on the rules regarding the rollover, direct rollover, and income tax withholding.

Select one of the distribution options below

- ❑ I instruct you to directly rollover 100% of the amount eligible to rollover to the eligible employer plan or Individual Retirement Account named in the Direct Rollover section below. I understand that Federal and State taxes will **not** be withheld as a result of this direct rollover.

- ❑ I instruct you to directly rollover $_____ or _____% of the amount eligible for rollover to the eligible employer plan or Individual Retirement Account named in the Direct Rollover section below. I instruct you to distribute to me the remaining balance of the distribution. I understand that Federal and State income taxes will **not** be withheld from the amount directly rolled over to the eligible employer plan or IRA named. The taxable portion of the amount distributed to me is subject to mandatory Federal income tax withholding at a rate of 20%, as required under current law and State income taxes will be withheld, if required by my state.

- ❑ I instruct you to distribute to me the total distribution requested on this form. I understand that Federal income taxes will be withheld on the taxable amount of the distribution at a rate of 20%, as required under the current law and State income taxes will be withheld, if required by my state.

Direct Rollover information (Complete only if one of the first two boxes are selected)

IRA Rollover
Trustee or IRA Custodian Name _____
IRA Account Number _____
Street Address _____
City, State & Zip _____

Rollover to another Qualified Plan
Trustee or IRA Custodian Name _____
Name of Plan _____
Account Number (if available) _____
Street Address _____
City, State & Zip _____

Section 3
Participant Signature

My signature below certifies that I have read the "Special Tax Notice Regarding Plan Payments" and (check one)

- ❑ I have at least 30 days to consider this election following receipt of these documents. (**Please note:** If this option is marked, Trust Company of America is required to hold this form for 30 days from the date signed, before processing).

- ❑ I understand that I have a right to a period of at least 30 days after receiving these documents to consider the decision of whether to make a direct rollover to an individual retirement account or another eligible employer plan, and I hereby waive my right to the 30 day period to make my election.

Marital status. I am: (check one) ( ) married ( ) not married

EXECUTED this _____ day of _____ , 20 _____ .

Participants Signature _____

Section 4
Spousal Consent

I, _____, spouse of the Participant hereby consent to the waiver of the Qualified Annuity Benefit and Qualified Optional Survivor Annuity and to the timing and form of distribution elected on this form. I have received a written explanation of the Qualified Annuity Benefit, my right not to consent to this waiver election, the waiver election period, and the financial effect of the election not to receive benefits in the form of the Qualified Annuity Benefit or Qualified Optional Survivor Annuity. I understand my consent is irrevocable unless my spouse revokes the waiver election. I understand any change in this form of benefit election is subject to my consent, unless my spouse elects to receive the Qualified Annuity Benefit or Qualified Optional Survivor Annuity.

EXECUTED this _____ day of _____ , 20 _____ .

Spouses Signature _____

NOTE: In order to consent, there must be a witness to spouse's consent by either a Plan Representative OR a Notary.

Witness by Plan Representative: _____

Signature of spouse witnessed this _____ day of _____ , 20 _____ .

_____
Plan Representative

OR

Witness by Notary:

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned, a Notary Public, personally appeared _____ who executed the above Spouse's Consent as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal this _____ day of _____, 20____.

(SEAL) Notary Public _____

My Commission expires: _____

Additional Distribution Information

Payment of Accounts of $1,000 or Less

If your vested account balance in the plan is $1,000 or less, your account may automatically be distributed to you in a lump sum check if this form is not returned within 30 days after issuance. Federal income taxes will be withheld on the taxable portion of the distribution at a rate of 20% as required under current law and state income taxes will be withheld if required by your state. You may also be subject to a 10% tax penalty if you are under the age of 59 1/2 and you do not roll over the taxable portion of the distribution within 60 days of your receipt of payment.

Payment of Accounts over $1,000

If your vested account balance exceeds $1,000 you may defer payment of your account until the 60th day after the year in which age 65 or retire, whichever is later. You may further defer your payment until April 1st of the year after which you reach the age 70 ½.

Outstanding Loan Balance Information

Any loan will be in default upon termination from employment. Since loan payments under the plan can only be made by salary deduction, unless you make payment for the total outstanding balance of the loan, the loan will be deemed to be in default. The outstanding loan balance will be taxable and will be reported to the Internal Revenue Service.

PLEASE RETURN THE COMPLETED FORM TO YOUR FORMER EMPLOYER. Trust Company of America cannot process this form without plan sponsor authorization.

Section 5

Plan Sponsor Authorization

I as the designated individual of the plan do hereby authorize the payment of this distribution as directed by this form.

Plan Sponsor Authorization _____ Date _____