DISTRIBUTION REQUEST FORM FOR SEPARATION OF EMPLOYMENT

Plan Name:

Please Print

Participant Name: _____

Address:_____
Street

_____
City State Zip

Date of Birth: _____

Date of Hire_____

Social Security # _____

Married_____ Single_____

Date of Separation from Employer: _____ Due to:
____Termination of Employment
_____Retirement
_____Death

Hours Worked in Plan Year of Separation:_____

Date_____ Trustee Signature_____

Fax to Omega, Inc., 315-449-4148