SOUTHERN STATES SAVINGS AND RETIREMENT PLAN TRUST FUND

576 Sigman Road, Suite 800
Conyers, GA 30013
770-922-3599 / 888-922-3599

Please fill in all personal information here to avoid delays in completing your request.	
Name	**Date of Birth**
Address	**Social Security #**
	Employer
Telephone #	**Local Union**
Date of Termination/Retirement	**Marital Status ☐M ☐S ☐D ☐W**
I am the: ☐ Participant ☐ Beneficiary	**Spouse Date of Birth**

Withdrawal Request Form

Please check the correct box and complete that section

I understand that first 8 weeks of the employer contributions were allocated to administrative expense and I am not entitled to theses funds

☐ **Withdrawal Employee Contributions**
I hereby request to withdraw ☐ ALL OR ☐ $_____from my employee contributions.
I understand I cannot make further withdrawals for one year from the date of this request.

Signed Date

☐ **Termination/Resignation Withdrawal Request/70 ½ Withdrawal**
This is to notify you I have terminated my employment effective _____
____ I hereby request to withdraw all funds deposited by the participant and/or employer
____ I hereby request to make a partial withdrawal in the amount of $_____
If Termed/Resign - I understand I must send you a copy of my termination or resignation letter.

Signed Date

☐ **Retirement, Disability or Deceased Withdrawal Request**
This is to notify you I have retired or become disabled effective _____ or Participant death on _____
____ I hereby request to withdraw all funds deposited by the participant and employer and close this account.
____ I hereby request to make a partial withdrawal in the amount of $ _____
I understand I must send you a copy of my termination or resignation letter.
In the death of a participant the Beneficiary understands that a copy of a Death Certificate must be provided.

Signed Date

☐ **Plan Terminated by Employer**
This is to notify you that my employer no longer participates in your retirement plan effective_____
I hereby request to withdraw ___ ALL funds OR ___ PARTIAL in the amount of $ _____ deposited by the participant and employer and close this account.

Signed Date

☐ **Suspend Employer Contributions**
This is to notify you that I wish to stop employee contributions. I understand I must notify my employer as well.

Signed Date

Signature must be witnessed by a Notary Public

State of _____

County of _____

Subscribed and Sworn to this _____ day of _____, 20 _____, before me the undersigned authority.

Notary Public _____

My Commission Expires _____

Prepared by SSRP administrative office