Thornburg

403(b) Plan Distribution Form

Mail Application To: Thornburg c/o DST, Post Office Box 219017, Kansas City, Missouri 64121-9017

This form is used to request a distribution from your 403(b). Be sure to fully complete ALL sections to ensure proper and speedy processing of you transaction.

Name of Employee | Date of Birth (MM/DD/YY)

Employee Address

Phone No. | Social Security Number

Fund/Account

1. Distribution Reason (To be completed by Employee or plan administrator–please select one option)

A. ❑ Termination of Employment ❑ Termination of Plan ❑ Retirement ❑ Disability

Date of Event (MM/DD/YY)

B. ❑ In-Service Transfer to other investment provider approved by my Employer's 403(b) plan.

2. Method of Distribution (To be completed by the Employee – please select one option)

❑ Total Distribution/Account Termination

❑ Partial distribution. Specify amount $ _____

❑ Distribute _____% of my account balance to me at the address provided above, and roll over _____% to the account identified below. (Note: total should equal 100%.)*

❑ In-Service Transfer _____% of my account balance to a 403(b) plan account at the investment provider below.*

❑ Direct Rollover of _____% of my account balance to a retirement account at the investment provider below.*

Please provide Direct Rollover information (Must be an eligible rollover distribution–see Special Tax Notice):

Type of rollover account: ❑ IRA ❑ Qualified Plan ❑ Non-spouse Inherited IRA ❑ Other _____

Investment Provider Name

Account Number

Account Name or Retirement Plan Name

Address

City | State | Zip

* For any of these options your signature must be Medallion Guaranteed in Section 5.

3. Method of Shipment

❑ Mail to Address of Record ❑ Wire* ❑ ACH* ❑ Special Payee Address*

Instructions

* For any of these options your signature must be Medallion Guaranteed in Section 5.

4. Income Tax Withholding (To be completed by the Employee)

I understand that this distribution will be reported to the Internal Revenue Service and the state of my residence, if applicable, as taxable income as appropriate. The address on this form will determine my state of residence for state withholding purposes. I also understand that the distribution will be subject to income taxes unless I roll over the distribution amount to another retirement account. Any distribution eligible for rollover that is greater than $200 is subject to 20% mandatory Federal Income Tax withholding unless I transfer or directly roll over the amount of the distribution to another retirement account. I further understand that, if I receive this distribution prior to age 59, the distribution may be subject to a 10% early withdrawal penalty. State taxes will be withheld at state's mandatory withholding rate, if applicable.

❑ Withhold Federal Income Tax at _____% of the total distribution (must be 20% or greater).

5. Employee's Authorization (Required)

I have read the "Special Tax Notice", attached hereto (unless previously provided to me by the Plan Administrator/Employer), and request the distribution, rollover or transfer from the retirement plan designated above. I wish to waive the 30-day notice period in order for my distribution rollover or transfer to be processed immediately. I understand a valid transfer, if requested, requires that my Employer approve the new investment and enter into an agreement with the investment provider named above.

Employee Name (please print) Employee Signature

Date

IMPORTANT: The signature must correspond exactly as your name appears in the account registration.

A Medallion Signature Guarantee Stamp is required under the following circumstances:

- Redemption over $25,000;
- The proceeds are being sent somewhere other than the address of record on your account, to a special payee or to new banking information;
- Your address has changed in the past 15 days.

This is not a complete list of requirements. Please contact a representative of the Fund at 800-847-0200 for more information.

Affix Guarantee Here

6. Plan Administrator's of Employer's Authorization and Vesting Verification (Required)

As Plan Administrator/Employer, I hereby certify that the vesting percentage for this Employee is equal to 100% and that the employee is eligible for the transfer or distribution requested above.

If a transfer is requested, I understand that the Employer must enter into a written agreement with the investment provider receiving this transfer as required by 403(b) regulations.

I authorize the distribution, direct rollover or transfer to be processed in the manner indicated above.

Plan Administrator's/Employer's Name (please print)

Plan Administrator's/Employer's Signature

Date