



Submit completed form to:
County Employees' Retirement Fund
 2121 Schotthill Woods Drive
 Jefferson City, MO 65101
 Toll Free: 877-632-2373
 Fax: 573-761-4404

FORM 2A
REFUNDS PAYMENT ELECTION
 Version 6.3

The participant **should receive a copy of the accompanying Instructions** and complete and sign this form indicating the election for payment of refunded contributions.

REFUNDS AND/OR ROLLOVERS WILL BE PROCESSED 60-90 DAYS FROM TERMINATION DATE

If you wish to have a portion of the payment made to you and a portion rolled over, mark both PAID TO ME and DIRECT ROLLOVER and indicate the amount of the payment you wish to have rolled over. In order for you to roll over all of your contributions, your contributions must equal at least \$200; otherwise, the payment must be made to you. If you have over \$500 in contributions, you may choose to have a portion paid to you and a portion rolled over. The part that is rolled over must total at least \$500. Unless otherwise noted, 100% of the balance will be rolled over.

NOTE: Direct deposits cannot be sent to a prepaid debit card/account.

<input type="checkbox"/>	Paid to Me (20% taxes will be withheld)		
	<input type="checkbox"/> Check		
	<input type="checkbox"/> Direct Deposit	<input type="checkbox"/> Checking Account (<u>attach voided check</u>)	<input type="checkbox"/> Savings Account (<u>attach voided deposit slip</u>)
	Name of Financial Institution: _____		
	Routing Number : _____ Account Number : _____		
<input type="checkbox"/>	Direct Rollover (rollovers will be paid via check and mailed to the participant)		
	<input type="checkbox"/> The rollover should be directed to the following eligible retirement plan. I certify that to the best of my knowledge, the following plan is an eligible retirement plan:		
	Name of Employer Plan (to whom to make the check payable)		
	<input type="checkbox"/> 100% Rollover OR <input type="checkbox"/> Partial Rollover	Account Number	_____
	Contact Person	Contact Phone Number	()
<input type="checkbox"/>	The rollover should be directed to the following IRA. The IRA to which my rollover should be directed is a (<i>check one</i>):		
	<input type="checkbox"/> Traditional IRA <input type="checkbox"/> Roth IRA		
	Name of IRA Plan/ Trustee/ Custodian/ Provider (to whom to make the check payable)		
	<input type="checkbox"/> 100% Rollover OR <input type="checkbox"/> Partial Rollover	Account Number	_____
	Contact Person	Contact Phone Number	()

NOTE: Participant is responsible for delivering rollover checks to the financial institution within 60 days of the date of the check.

REQUIRED SIGNATURE (See below)

Social Security Number X X X - X X - County of Previous Employment _____

First Name _____ Initial _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone () _____

Is your termination due to moving to either a Sheriff or Prosecuting Attorney position? Yes No

I hereby certify that I have not returned, nor will I return, to county employment, in an eligible position, within 30 days of my last termination date, or am not currently working for another county and acknowledge that I have been given a copy of the accompanying Instructions and hereby elect the form of distribution I have indicated above.

Signature of Participant	Date
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