Paycor

Loan Offset For Account Reduction Loans
401(k) Plan

Paycor, Inc. 401(k) Plan **195019-01**

For My Information

- *For questions regarding this form, visit the Web site at empowermyretirement.com or contact Service Provider at 1-844-465-4455.*
- *Use black or blue ink when completing this form.*

A Participant Information

Account extension identifies funds transferred to a beneficiary due to death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

U.S Social Security/U.S Taxpayer Identification Number
(Must provide all 9 digits)

Last Name First Name M.I.

(The name provided MUST match the name on file with Service Provider.)

( ) Daytime Phone Number

( ) Alternate Phone Number

Email Address

***Select One** (Required):*

❑ I am a U.S. Citizen or U.S. Resident Alien.

❑ I am a Non-Resident Alien or Other. *(Complete 'Non-Resident Alien or Other Certification' section.)*

Required - Provide Country of Residence: _____

B Loan Offset Reason

❑ Separation from Employment - Date *(Required)*: ____/____/____

❑ Disability - Date *(Required)*: ____/____/____

❑ Age 59 ½ or older

❑ Death *(Attach a certified copy of the death certificate)*

Loan number(s) to be offset: _____

C Non-Resident Alien or Other Certification

Complete only if I indicated I am a non-resident alien or other under Section A of this form.

(Continue to the next section after completing.)

Do not complete if U.S. Citizen or U.S. Resident Alien was indicated in Section A of this form.

Under penalty of perjury, if I checked Non-Resident Alien or Other in Section A of this form, my signature certifies that:

- I am the individual that is the beneficial owner of all the income to which this form relates or is using this form to document myself for chapter 4 purposes.
- I am not a U.S. person.
- The income to which this form relates is:
  a. not effectively connected with the conduct of a trade or business in the United States,
  b. effectively connected but is not subject to tax under applicable income tax treaty, or
  c. the partner's share of a partnership's effectively connected income.
- I am a resident of the treaty country listed below under the "Claim of Tax Treaty Benefits" (if any) within the meaning of the income tax treaty between the United States and that country.
- I agree that I will submit a Form W8-BEN within 30 days if any certification made on this form becomes incorrect.

Identification of Beneficial Owner

Country of citizenship

Foreign tax identifying number

Permanent resident address *(street, apt. or suite no., or rural route)* **Do not use P.O. Box or in-care of address**

City or town, state or province. Include postal code where appropriate. Country

Mailing Address *(if different from above)*

City or town, state or province. Include postal code where appropriate. Country

Claim of Tax Treaty Benefits *(for chapter 3 purpose only)*

I certify that the beneficial owner is a resident of _____ within the meaning of the income tax treaty between the United States and that country.

Special rates and conditions (if applicable): The beneficial owner is claiming the provisions of Article and paragraph _____ of the treaty identified on the line above to claim a _____% rate of withholding on (specify type of income):

Explain the additional conditions in the Article and paragraph the beneficial owner meets to be eligible for the rate of withholding:

Last Name	First Name	M.I.	U.S. Social Security Number	195019-01 Number

D **Signatures and Consent** *(Signatures must be on the lines provided.)*

Participant/Beneficiary Consent *(Please sign on the 'Participant/Beneficiary Signature' line below.)*

This loan offset must be for the entire outstanding loan balance indicated on this form. If I have multiple loans and I have not indicated a loan number, all loans will be offset. I may be required to complete a new form or provide additional or proper information before the loan offset can be processed, in the event that any section of this form is incomplete or inaccurate. Any subsequent payments received on the loan number(s) indicated on this form will be refunded. An appropriate tax reporting form will be issued for the year in which the Loan Offset occurred.

I understand that if I have selected Disability as the loan offset reason, I must obtain either:

1. My physician's signature in 'Physician's Information and Certification of Disability' section, Or:
2. My Plan Administrator's certification. The certification must include ALL of the following: A) a check mark in the box provided; B) the date of my disability on the line provided; and C) the signature and date of my Plan Administrator in 'Authorized Plan Administrator Signature' section.

My signature acknowledges that I have read and understand this entire form and the possible tax consequences of this request and affirm that all information that I have provided is true and correct. Where I deem appropriate, I will seek a consultation with my tax advisor.

If I selected non-resident alien or other above, I must complete the 'Non-Resident Alien or Other Certification' section on this form. I may call 1-800-TAX-FORM (829-3676) or visit irs.gov for futher information.

Under penalty of perjury, I certify that the U.S. Social Security number or U.S. Taxpayer Identification number I have provided in Section A is correct. I am a U.S. person if I marked the U.S. Citizen or U.S. Resident Alien box in Section A of this form.

Any person who presents false or fraudulent information is subject to criminal and civil penalties.

Participant/Beneficiary Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Physician's Information and Certification of Disability *(Please sign on the 'Physician's Signature' line below.)*

Physician's Name	*Name of Practice*
Physician's Mailing Address	*Physician's City/State/Zip Code*
( ) *Physician's Phone Number*	( ) *Physician's Fax Number*

Section §72(m)(7) of the Internal Revenue Code provides that a person is disabled "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration." Federal Treasury regulations provide that the "substantial gainful activity" to which §72(m)(7) refers is "the activity or a comparable activity in which the individual customarily engaged prior to the arising of the disability or prior to retirement if the individual was retired at the time the disability arose."

I, _____ *(Physician's printed name)*, under penalty of perjury, hereby certify that _____ *(Participant's printed name)*

is my patient who became totally and permanently disabled on _____/_____/_____ *(Date - mm/dd/yyyy)* and has met and continues to meet the IRC §72(m)(7) definition of disability.

Physician's Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Authorized Plan Administrator Signature *(Please sign on the 'Authorized Plan Administrator Signature' line below.)*

The information provided by the participant/beneficiary is correct. This loan offset is in compliance with the Plan provisions. Process the loan offset for the reason described in this form.

I certify that the Participant met the disability requirements under the Plan document and is eligible to take this withdrawal.

❑ I certify that the Participant's disability meets the IRC §72(m)(7) definition of disability and the date of their disability is _____/_____/_____. *(mm/dd/yyyy)*

I represent that I am an authorized signer on behalf of the above-named plan and have an authority to instruct Service Provider to process this form.

Authorized Plan Administrator Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Print Full Name _____

Last Name	First Name	M.I.	U.S. Social Security Number	195019-01 Number

E Mailing Instructions

After all signatures have been obtained, this form can be

Uploaded Electronically:	**OR**	**Sent Regular Mail to:**	**OR**	**Sent Express Mail to:**
Login to account at **empowermyretirement.com** Click on Upload Documents to submit		Empower PO Box 173764 Denver, CO 80217-3764		Empower 8515 E. Orchard Road Greenwood Village, CO 80111

We will not accept hand delivered forms at Express Mail addresses.