

**CENTRAL MAINE HEALTHCARE CORPORATION 457 PLAN
HARDSHIP DISTRIBUTION REQUEST**

Name: _____

Address: _____

Social Security Number: _____

You are responsible for completing this form truthfully. If you have made an obvious misstatement, we will ask you to correct it. You may be asked to provide proof of the immediate and heavy financial need to the Plan Administrator.

PART A. Amount Needed

I need \$_____, to cover a hardship including estimated taxes on this amount. I further confirm that I have no other funds reasonably available to me to satisfy these obligations.

PART B. Nature of Hardship

I need this entire amount to cover (check one):

1. Medical expenses incurred by me, my spouse or dependent.
2. Tuition for the next semester or quarter of post high school education for me, my spouse, children, or dependents.
(dependent is someone you can claim on your federal tax return.)
3. The purchase (excluding mortgage payments) of my principal residence.
4. Avoidance of eviction or mortgage foreclosure in connection with my principal residence.
5. The following other immediate and heavy financial need:

PART C. Taxes

I understand that federal and state taxes are not required to be withheld from my hardship distribution and, therefore will not automatically be withheld. If I want taxes withheld from my distribution, I will check the appropriate box below:

- No Taxes - This is the default if none are chosen.
- Federal Taxes - 20%
- State Taxes - % varies by state

**CENTRAL MAINE HEALTHCARE CORPORATION 457 PLAN
HARDSHIP DISTRIBUTION REPORT TO PARTICIPANT**

Your distribution request dated _____, copy attached, is:

Approved Disapproved for the following reason

Your request showed this net amount needed: \$ _____

The total amount approved for disbursement, if less than your total need, is the greatest amount available to you under the plan at this time.

(If checked) You must complete and sign the attached forms before disbursements can be made.

Authorized Signature

Date

Please return one copy of this form, countersigned below, to indicate you wish to receive the total disbursement as approved.

Participant's Signature

Date

SPOUSAL CONSENT TO HARDSHIP WITHDRAWAL

I hereby consent to the foregoing conditions of the hardship withdrawal to my spouse in the amount of \$ _____ from the Central Maine Healthcare Corporation 457 Plan.

Date

Spouse's Signature

Notary Public or Plan's Designated Representative