

**Cement & Concrete Workers District Council Annuity Fund
Coronavirus-Related Distribution Form**

PARTICIPANT NAME	SOCIAL SECURITY NUMBER
	XXX - XX - ____

Under the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), you are eligible to request, from now until December 15, 2020, **one** coronavirus-related distribution (CRD) from the Annuity Fund of up to **\$50,000*** or **50%** of your account balance, whichever is less, determined on the date the distribution is processed. This one-time distribution is not subject to the Plan provisions limiting the number of withdrawals a participant may take each year.

As part of this withdrawal application process, you must complete the following COVID-19 Distribution Certification:

I certify that I meet one or more of the following criteria:

- I, my spouse, or my dependent has been diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention (CDC), or
- Due to the coronavirus, I have experienced adverse financial consequences because of:
 - Being quarantined, furloughed, laid off, or having my work hours reduced, or
 - My inability to work due to lack of childcare, or
 - Other financial hardship due to the COVID-19 pandemic.

I certify that this request, when combined with any other coronavirus-related distributions I have received from this Plan or other plans and IRAs, does not exceed the CARES Act limit of \$100,000.

Dated: _____, 2020 Signature: _____

I. AMOUNT OF DISTRIBUTION:

I request a distribution from my account in the amount of:

\$_____ (fill in the dollar amount)

You may obtain the dollar amount of your account by accessing the John Hancock website at www.bcomplete.com or by contacting the Fund Office at 718-762-6133. As a reminder, you cannot request more than the lesser of \$50,000 or 50% of your account balance. If the amount available to withdraw is less than the amount you requested, you will receive the maximum amount allowed to be withdrawn.

II. TAX WITHHOLDING INFORMATION:

Unless you elect otherwise, you will be subject to 10% withholding for federal income taxes, plus any applicable state tax withholding. The 10% early withdrawal penalty does not apply, and the distribution may not be rolled over directly to an IRA or retirement plan. You may elect to pay the tax on this distribution over three years. In addition, this distribution may be paid back to a retirement plan or IRA in single or multiple payments over three years. You are encouraged to consult your tax professional for advice on the applicable tax rules. The Fund cannot give tax advice.

ELECT ONE OPTION:

- A.** I **elect** to have federal income tax, at the rate of 10%, and state income tax (if applicable) withheld from my Coronavirus-Related Distribution.

Additional Amount to be Withheld (if any): \$_____

- B.** I **do not elect** to have federal or state income tax withheld from my coronavirus-related distribution.

*If no election is made, 10% will automatically be withheld from your distribution for federal income tax.

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III. MARITAL STATUS:

I am legally married. YES NO

If you checked "YES," your spouse must complete the attached **SPOUSAL CONSENT FORM** if this distribution is greater than \$5,000.

IV. OTHER IMPORTANT INFORMATION:

I understand that I have the option to have this distribution directly deposited into my bank account by accessing mylife.jhrps.com to set up my banking information or to confirm existing banking information on file, if applicable.

I also understand that the payment amount may be less than the specific dollar amount I have requested above due to Plan limitations and/or market fluctuations that may affect the amount available for withdrawal at the time payment is made.

I certify that there is no pending domestic relations order or court approved domestic relations order which has, or will, assign all or a part of my Plan account to my spouse, former spouse, child or other dependent. I understand that a false statement by me may result in legal damages for which I will be fully responsible.

Date: _____ Participant Signature: _____

WITNESSED BY NOTARY PUBLIC (To be completed by Notary Public)

State of _____ County of _____ ss.

On this, the ____ day of _____, 20__, before me personally appeared _____ known (or satisfactorily proven) to me to be the person who executed the foregoing. In witness whereof, I hereunto set my hand and official seal.

Signature of Notary Public _____ (SEAL)

My Commission Expires: ____/____/____

TO BE COMPLETED BY PLAN ADMINISTRATOR

The request for the above Participant is: APPROVED NOT APPROVED

If approved, the Custodian is hereby authorized to process the request.

Plan Administrator: _____ Date: _____

Date form received by Plan Administrator: _____

**Return this form by mail to:
CCWBF Fringe Benefit Funds
35-30 Francis Lewis Blvd. Suite 201, Flushing, NY 11358**

You can also drop this form in the Drop Box at the Fund Office.

The Fund Office must receive your completed application by December 15, 2020.