RESET FORM

CANCELLATION REQUEST

Mississippi Deferred Compensation Plan & Trust (MDCPT)
PO Box 105, Jackson, MS 39205
Phone: 800-846-4551 or 601-364-9350 Fax: 601-362-4021

mdc
PLAN • SAVE • GROW

To ensure proper authorization, you must initial any cross-outs made on this request. Complete this request and mail to the location above.

1. PARTICIPANT INFORMATION

Name _____ SSN ***(Required)*** _____

Mailing Address _____ Daytime Phone _____

City _____ State _____ ZIP _____

Agency/Employer Name _____

2. REVOCATION EFFECTIVE DATE

To the Third Party Administrator:

In accordance with the provisions of the Deferred Compensation Plan, I hereby elect to revoke my active participation in the Plan effective the first day of _____
(month, year)

PLEASE NOTE: ALL CANCELLATION NOTICES MUST BE RECEIVED IN THE DEFERRED COMPENSATION OFFICE PRIOR TO THE FIRST DAY OF THE MONTH YOU DESIRE THE CANCELLATION TO BE EFFECTIVE.

3. PARTICIPANT SIGNATURE AND AUTHORIZATION

I understand that my membership in the Plan shall be continued, but no further deductions shall be made on my behalf. I also understand that I may reinstate active participation by completing a Participation Agreement. The Agreement must be received in the MDCPT office prior to the first day of the effective month.

(You are not required to make a distribution election with your Mississippi Deferred Compensation Plan & Trust account when you sever employment unless you are 70½ or older. Once you sever employment, you must begin a distribution by April 1 of the calendar year following the calendar year in which you attain 70½.)

Participant Signature _____ Date _____