(Use this Form to accompany a Rollover check into the HART Plan.)

Transfer/Rollover Form - 180

## Housing Agency Retirement Trust

Social Security #:		-	-	-											
Employee Name:															
Employee Nume.	Last, First,	Middle	e												
Address:	<b>.</b> .														
	Street												Apt.		
	City							S	tate		Zip C	ode			

HART

## **TRANSFER/ROLLOVER INSTRUCTIONS**

This Transfer/Rollover Form is used to invest prior plan money in your Plan account. The rollover must be completed within 60 days of receipt of the distribution, come from an IRA or from another employer s plan and represent all or a portion of a lump sum distribution, or an installment distribution of less than ten years. In the context of a direct rollover or transfer, in which the funds are never actually made payable to you, the 60-day period for completing a rollover is inapplicable.

Identify the total amount of the Transfer/Rollover. A certified or bank check must accompany this form for the stated dollar amount. Pre-printed checks are required. Section II.A. Handwritten checks will be returned. Please include your Agency Plan Number on the check made payable to State Street Bank and Trust. Section II.B. Check  $(\sqrt{)}$  the appropriate box to identify the source of this Transfer/Rollover.

Section II.C. This rollover may include after-tax contributions.

Read the acknowledgment and then sign and date the form. Section III.

Note: If you have not previously enrolled in the Plan, please complete an Enrollment Form #110, which is available online at www.hart-retire.com.

AM	DUNT/SOURCE OF TRANSFER/ROLLOVER		This is a full	
Α.	Enter the dollar amount of monies to be transferred/rolled into the plan. \$	controlocomination in the second second	This is a Full Transfer/Rollover	This is a Partial Transfer/Rollover
B.	This transfer/rollover must be a distribution from one of the following "Eligible Retiren a 401(a) or 401(k) Plan. Other acceptable transfer/rollover sources include: "IRA, SE appropriate box below and obtain from your previous plan administrator verification i check. We must receive this information before we can accept the transfer/rol § 457(b) Plan \$ \$403(b) Tax Sheltered Annuity IRA	P-IRA, SIMPLE IRA (if funds have n writing that it is one of these type	been in account at least 2 es. <b>Please enclose that v</b>	years)". Please check the
300000	SEP-IRA SIMPLE IRA	Address:		
	Qualified Plan of (check one):	City:	State:	Zip:
	an Unrelated Employer 🛄 a Related Employer	Phone: Current Account #:		

Note: This Plan does accept transfer/rollovers of after-tax contributions. If applicable, please provide signed verification of the after-tax amount from your prior recordkeeper. C.

## ACKNOWLEDGMENT, TRANSFER/ROLLOVER INVESTMENT DIRECTION AND SIGNATURE

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I have read and understand the summary of the plan, have completed the Beneficiary Form if I have not previously enrolled in the plan, and agree to be bound by the provisions of the Plan. I have also reviewed a current prospectus and description of each of the funds, and understand the objectives, risks, expenses and charges associated with each. I certify that:

- I received the distribution from the source indicated above within the last 60 days (60-day requirement not applicable in the case of a direct rollover).
- The transfer/rollover is from the rollover source indicated above and has not been combined with any money that would disqualify the transfer/rollover.
- No portion of this rollover contribution represents amounts received as a hardship distribution from an employer plan.

If I do not yet have an account balance under the Plan, I understand that I need to complete the Enrollment Form #110 and enclose with this form. I understand that my rollover contribution will be invested in accordance with my investment election on file, unless I contact the recordkeeper to instruct otherwise.

Signature of Employee/Participant	Name of Housing Agency		Daytime Phone Number	Date	
Send this form, rollover check, and verification of the rollover source. If applicable confirm any after-tax amounts.	<u>Regular Mail:</u> ADP NJ CRS P.O. Box 13399 Newark, NJ 07101-3399	ADP Atte Lock 100	Overnight Mail: ADP C/O FIS Attention: Lockbox 13399 Lockbox Dept Suite E 100 Grove Road		
	Phone: 1-888-801-3	3534 wes	t Deptford, NJ 08066		
	Fax: 973-712-74	89			
	FOR PLAN ADMINISTRATOR USE	E ONLY (MUST BE COMPLETI	ED)		
	Date Received:	HART/ADP Approva	al:		

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Plan #

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