INSURANCE PREMIUM PAYMENT REQUEST FORM

Instructions: Before completing the insurance premium payment request form, please make sure that your Plan permits life insurance policies. Use this form to request payment of your insurance policy premium from your retirement plan asset. When submitting this form for processing, **be sure to attach a PDF copy of your most recent unpaid invoice or payment notice from your insurance provider**. Note that payments may only be made from vested balances in your Employee Deferral or Employer Profit Sharing accounts. Please type or print all entries in full (no redactions please). Return your completed form and invoice/ payment notice to RPG Consultants for processing (5-15 business day processing timeline). Processing fees apply. You may upload your completed form using RPG's secure file transfer portal at https://files.rpgconsultants.com/filedrop/Support.

SECTION A - PERSONAL INFORMATION

Plan Name:		Social Security No.:	
Participant Name:		Date of Birth:	
Address:		Date of Hire:	
Apt/Suite:		E-mail Address:	
City, State, Zip:		Phone #:	

SECTION B - PAYMENT AMOUNT & DESTINATION

Insured Name:	
Insurance Provider:	
Policy Number:	
Payment Amount:	

SECTION C - SOURCE OF PAYMENT

Enter the Source(s) in your retirement account from which payments to your insurance provider should be made. Note that payments may only be made from vested balances in your Employee Deferral or Employer Profit Sharing Source accounts

Source Account:		Percent:	%	or	Amount:	$
Source Account:		Percent:	%	or	Amount:	$
Source Account:		Percent:	%	or	Amount:	$
Source Account:		Percent:	%	or	Amount:	$

Participant:

I have attached a copy of and hereby request payment of the enclosed unpaid invoice/ payment notice for my life insurance policy premium from vested amounts in the Source accounts indicated above in my retirement plan account. I certify that all entries made on this form are accurate to the best of my knowledge. I understand that a processing fee will apply, and that the processing timeline ranges between 5 and 15 business days from receipt of a completed payment request form.

Date _____ Name (Please Print) _____ Signature _____

Plan Trustee:

I certify that am a Plan Trustee, and as a Trustee, I authorize the above insurance premium payment from the retirement plan.

Date _____ Name (Please Print) _____ Signature _____