

**Certification of Disability
401(k) Plan**

Any disability certification other than this form will not be accepted.

Apollo Professional Solutions, Inc. 401(k) Plan

937620-01

Participant Information

| | | |
|---------------------------|------------|----------|
| _____ | _____ | _____ |
| Last Name | First Name | MI |
| _____ | | |
| Address - Number & Street | | |
| _____ | _____ | _____ |
| City | State | Zip Code |
| () _____ | () _____ | |
| Home Phone | Work Phone | |

Social Security Number

Account Extension (if applicable)

Required Signatures

I have requested a distribution due to disability. I understand that in order for the payor to reflect my distribution on the appropriate tax reporting form as a distribution due to disability and exempt from the Internal Revenue Service ("IRS") 10% premature distribution tax (if I am under age 59 1/2), I must obtain my physician's or Plan Administrator's signature on the statement below that my disability meets the definition found under Internal Revenue Code §72(m)(7). Such definition provides that a person is disabled "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration." Federal Treasury regulations provide that the "substantial gainful activity to which §72(m)(7) refers is the activity, or a comparable activity, in which the individual customarily engaged prior to the arising of the disability or prior to retirement if the individual was retired at the time the disability arose."

Participant Signature

Date

Certification of Disability

I, _____, hereby certify that _____
(Physician's printed name) (Participant's printed name)
is my patient, and meets the Internal Revenue Code §72(m)(7) definition of disability as noted above.

Physician's Signature

Date

OR

Statement of Plan Administrator

I certify that this participant meets the Internal Revenue Code §72(m)(7) definition of disability as noted above.

Plan Administrator Signature

Date

Please attach this form to your Distribution/Direct Rollover Request form.

Participant forward to Service Provider at:
Great-West Retirement Services®
PO Box 173764
Denver, CO 80217-3764
Express Address:
8515 E. Orchard Road, Greenwood Village, CO 80111
Phone#: 1-800-338-4015
Fax#: 1-866-633-5212

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