



# Accumulation Program for Part-Time and Limited-service Employees

## REQUEST FOR REFUND OF CONTRIBUTION

### To be completed by Plan Sponsor personnel

Employer Name:		Contact Name:
Address:		City, State Zip:
Telephone Number:	Fax Number:	E-mail Address:

Contributions for the following employee(s) were mailed in error:

Employee Name \_\_\_\_\_  
 Employee SSN \_\_\_\_\_  
 Amount Contributed in Error EE \$ \_\_\_\_\_ ER \$ \_\_\_\_\_

Employee Name \_\_\_\_\_  
 Employee SSN \_\_\_\_\_  
 Amount Contributed in Error EE \$ \_\_\_\_\_ ER \$ \_\_\_\_\_

Employee Name \_\_\_\_\_  
 Employee SSN \_\_\_\_\_  
 Amount Contributed in Error EE \$ \_\_\_\_\_ ER \$ \_\_\_\_\_

Employee Name \_\_\_\_\_  
 Employee SSN \_\_\_\_\_  
 Amount Contributed in Error EE \$ \_\_\_\_\_ ER \$ \_\_\_\_\_

Employee Name \_\_\_\_\_  
 Employee SSN \_\_\_\_\_  
 Amount Contributed in Error EE \$ \_\_\_\_\_ ER \$ \_\_\_\_\_

There will be no offsetting negative contribution. Please refund the total amount of \$ \_\_\_\_\_.  
 I understand that the refund will only be made payable to the Plan Sponsor.

\_\_\_\_\_  
Plan Sponsor Signature/Title

\_\_\_\_\_  
Date

Please return this completed form to:  
 MidAmerica Administrative Solutions  
 Attn: APPLE  
 211 East Main Street, Suite 100, Lakeland, FL 33801  
 Fax: (863) 686-9727