Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID:**DIOCSELACQ**	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) **Diocese of La Crosse**			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Long Term Disability ☐Yes ☐No	$	

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE		AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐Yes ☐No*	$	$
Voluntary Spouse Life Insurance	☐Yes ☐No*	$	$
Voluntary Dependent Child Benefit	☐Yes ☐No*	$10,000	$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

Please See Last Page for Beneficiary and Signature

C. Beneficiary Information (Complete ONLY for Life/AD&D)					
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

D. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ☐ **NOT ENROLL my dependents in the Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

Employee Full Name:_____ Employee Signature:_____ Date:_____

Benefit Plan Administrators

ENROLLMENT FORM

BPA Use Only
Effective Date: _____

Parish/Institution _____ # _____ City _____ Group # 8201

Last Name _____ First Name _____ MI _____ Date of Birth ___/___/___ Social Security No. ___/___/___

Street Address _____ Home Phone Number _____

City _____ State _____ Zip _____ Personal Email _____

Marital Status ___ Single ___ Married ___ Divorced ___ Widowed Job Title _____ Hours per Week _____ First Date of Work _____

BENEFITS REQUESTED: *(Employees electing medical will be enrolled automatically with the same vision coverage.)*

All employees are under The Alliance PPO network.
Check for providers at www.the-alliance.org. Select Find a Doctor at the top. Enter your location & choose The Alliance Standard Network for "Your Plan". You can search doctors & facilities by name or type.

MEDICAL ___ Employee ___ Family Plan: ___ Traditional ___ HDHP/HSA Plan*
** HDHP will have a higher individual deductible if family elected.*

VISION: ___ Employee ___ Family *(if no medical elected)*

DENTAL ___ Employee ___ Employee+1 Dep ___ Family

LIFE / AD&D ___ $20,000 (Please list beneficiary at right)
Primary Beneficiary* _____ Relationship _____
Contingent Beneficiary _____ Relationship _____

**If anyone other than your spouse is named as primary beneficiary, you need to read & have your spouse sign on the back and return with the application*

I understand that if not elected now evidence of insurance may be requested if I later decide to enroll in life insurance, & my application may be rejected.

DEPENDENTS: Please only list dependents to be covered under this plan. (Include last name if different from employee's.)

Name of Dependent	Date of Birth	Sex	Social Security No.
Spouse	___/___/___		___/___/___
Child	___/___/___		___/___/___
Child	___/___/___		___/___/___
Child	___/___/___		___/___/___
Child	___/___/___		___/___/___
Child	___/___/___		___/___/___

OTHER INSURANCE COVERAGE: As of your effective date, will there be any other insurance in effect on you or any dependents to be covered?
YES ___ NO ___
If Yes, primary insured name: _____
Family Members covered: _____

If Yes, other insurance coverage is:
Medical: Employee ___ Family ___
Vision: Employee ___ Family ___
Dental: Employee ___ Family ___
Carrier Name: _____

WAIVER OF BENEFITS (Must sign below even if waiving coverage)

I, the undersigned, an employee of the above named policy holder, hereby certify that I have been given an opportunity to apply for group insurance benefits as offered by my employer and after careful consideration, I hereby waive my right to:

___ Life Insurance Medical: ___ Employee ___ Family Vision: ___ Employee ___ Family Dental: ___ Employee ___ Family ___ Employee + 1

Reason for waiving coverage: _____

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION

I enroll for the benefits I indicated in the BENEFITS REQUESTED section which will be provided by the group plan I am eligible for. I authorize deductions from my earnings if required. I have the right to revoke this deduction authorization, as permitted under any Section 125 plan in place by my employer (if applicable), if I do so in writing on forms required by such plans. I refuse the benefits I indicated in the WAIVER OF BENEFITS section.

I authorize any physician, medical or dental practitioner, hospital, clinic, other medical related facility, insurance or reinsurance company, having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of myself, my spouse or my minor children and any non-medical information on myself, my spouse or my minor children to give to Benefit Plan Administrators of Eau Claire Inc. or their legal representative any and all such personal health information necessary for benefit determination, payment, treatment or plan operations.

I further authorize Benefit Plan Administrators of Eau Claire Inc. to pay benefits directly to the provider unless otherwise indicated at the time of claim submission.

Any information obtained will not be released by Benefit Plan Administrators of Eau Claire Inc. to any person or organization except to reinsuring companies, or any other persons or organizations performing business or legal services in connection with my application, the processing of claims or as may be otherwise lawfully required. For more information on possible release of information, I can contact Benefit Plan Administrators of Eau Claire Inc. for a copy of their privacy policy. I will be notified of any subsequent changes to that policy.

I know that I may request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization is valid for two years from the signature date. Authorization may be revoked by written request.

I hereby certify that all the information shown above is true and correct to the best of my knowledge. I also understand that any false information listed will null and void this application and the coverage for which it applies. The plan reserves the right to rescind coverage should the above information prove not to be complete or accurate.

_____ _____
Signature of Employee (Required) **Date Signed** (OVER)

ADDENDUM TO APPLICATION FOR LIFE INSURANCE BENEFICIARY

Community Property State Consent for residents for Wisconsin: If you are married, live in a community state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.

As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such life insurance under applicable community property laws.

Signature of Spouse _____ Date _____

OTHER IMPORTANT PLAN INFORMATION

Notice of Enrollment Rights:

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I have other coverage, I may later apply for coverage for me and/or my dependents if eligibility is lost under that other coverage, if the employer stops contributing toward the other coverage or if adding a dependent due to marriage, birth, adoption or placement for adoption. Loss of eligibility may result from one of the following:

1. My spouse loses coverage due to job termination or has a reduction in hours to a status that is ineligible for coverage;
2. My spouse and I divorce;
3. My spouse dies; or
4. The expiration of COBRA for a previous employer.

I am aware if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I do not want coverage for whatever reason, I may later apply for coverage for myself and/or my dependents with a marriage or the birth adoption or placement for adoption of a child.

In addition, you may add a new dependent to your plan as a result of a marriage, birth, adoption or placement for adoption. Application to add a new dependent must be made within 31 days of the event.

If you qualify for enrollment under any of the above exceptions you must complete and return the signed application to Benefit Plan Administrators of Eau Claire Inc. (BPA) or your employer within 31 days of the qualifying event. When adding a dependent to your existing policy, you must complete and return a signed change form to BPA or your employer within 30 days of the marriage, birth, adoption or placement for adoption.

You may also apply for coverage for you and any eligible dependent during the open enrollment period each year.

If you have any questions, you may contact Benefit Plan Administrators of Eau Claire Inc. at 1-800-236-7789.

Eligibility and Effective Date of Coverage:

For newly hired employees, coverage is effective the first of the month following employment in a benefit eligible position.

Age Limits for Dependent Children:

Coverage for eligible children will cease at the end of the month in which the child reaches the age of 26.

MUTUAL OF AMERICA LIFE INSURANCE COMPANY
320 PARK AVENUE NEW YORK NY 10022-6839
800 468 3785 OR CALL YOUR LOCAL REGIONAL OFFICE

Employee Enrollment Form for 403(b) Thrift Plans With Designated Roth Contributions and Consent to Receive Electronic Documents (eDocuments)

TO BE COMPLETED BY PLAN ADMINISTRATOR

EMPLOYER'S NAME

EMPLOYER NUMBER

DATE EMPLOYEE HIRED
/ /

EMPLOYMENT STATUS
☐ FULL-TIME
☐ PART-TIME

PART TIME SERVICE
If this employee ever worked on a part-time basis, enter the date on which the 1,000-hour requirement was met, in accordance with plan specifications

DATE 1,000 HOURS COMPLETED

PRIOR TAX-EXEMPT SERVICE
If during the last three years this employee had service with another eligible organization that is to be counted toward meeting eligibility requirements, enter the number of months of such service that are to be counted

NUMBER OF MONTHS

EMPLOYEE'S SALARY RATE
$
☐ (A)nnual ☐ (B)iweekly
☐ (M)onthly ☐ (W)eekly
☐ (S)emimonthly

EMPLOYEE'S DEPARTMENT * (IF APPLICABLE)

EFFECTIVE DATES
Enter the effective date and the percentages of salary or dollar amount for Traditional Pre-tax and Designated Roth Contributions (after-tax) in the applicable areas.

TRADITIONAL PRE-TAX CONTRIBUTIONS

PERCENT OF SALARY	DOLLAR AMOUNT	EFFECTIVE DATE
%	OR $	/ /

EMPLOYER CONTRIBUTIONS

EMPLOYER MATCHING EFFECTIVE DATE	EMPLOYER NON-MATCHING EFFECTIVE DATE
/ /	/ /

DESIGNATED ROTH CONTRIBUTIONS (AFTER-TAX)

PERCENT OF SALARY	DOLLAR AMOUNT	EFFECTIVE DATE
%	OR $	/ /

SECTION 1 - EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER

EMPLOYEE'S NAME First Initial Last

MAILING ADDRESS Street and Number City State Zip Code

IF FOREIGN RESIDENT Province Country

DATE OF BIRTH
/ /

☐ MALE
☐ FEMALE

TELEPHONE NUMBERS
HOME ( )
OFFICE ( )

To receive your documents electronically and "go green," please complete Section 5.

SECTION 2 - ALLOCATION OF CONTRIBUTIONS

Show the percentage of your contributions you want to place in the Interest Accumulation Account of our General Account and/or Separate Account investment funds. **Use whole numbers only, and make sure the percentages total 100%.**

Amounts placed in the Interest Accumulation Account will be credited with the rate of interest applicable to that account. Your balance in any investment fund will fluctuate to recognize investment results.

Interest Account

_____% Mutual of America Interest Accumulation Account

Separate Account Investment Funds

Separate Account – Equity Funds (24)

_____% Mutual of America Equity Index Fund
_____% Mutual of America All America Fund
_____% Mutual of America Small Cap Value Fund
_____% Mutual of America Small Cap Growth Fund
_____% Mutual of America Small Cap Equity Index Fund
_____% Mutual of America Mid Cap Value Fund
_____% Mutual of America Mid-Cap Equity Index Fund
_____% Mutual of America International Fund
_____% Fidelity® VIP Mid Cap Portfolio
_____% Fidelity® VIP Equity-Income Portfolio
_____% Fidelity® VIP Contrafund® Portfolio
_____% Vanguard VIF Diversified Value Portfolio
_____% Vanguard VIF International Portfolio
_____% Goldman Sachs VIT US Equity Insights Fund
_____% Goldman Sachs VIT Small Cap Equity Insights Fund
_____% American Century VP Capital Appreciation Fund
_____% American Funds Insurance Series® New World Fund®
_____% Delaware VIP® Small Cap Value Series
_____% DWS Capital Growth VIP
_____% Invesco Oppenheimer V.I. Main Street Fund®
_____% MFS® VIT III Mid Cap Value Portfolio
_____% Neuberger Berman AMT Sustainable Equity Portfolio
_____% T. Rowe Price Blue Chip Growth Portfolio
_____% Victory RS Small Cap Growth Equity VIP Series

Separate Account – Asset Allocation Funds (3)

_____% Mutual of America Conservative Allocation Fund
_____% Mutual of America Moderate Allocation Fund
_____% Mutual of America Aggressive Allocation Fund

Separate Account – Fixed Income Funds (5)

_____% Mutual of America Money Market Fund
_____% Mutual of America Mid-Term Bond Fund
_____% Mutual of America Bond Fund
_____% PIMCO VIT Real Return Portfolio
_____% Vanguard VIF Total Bond Market Index Portfolio

Separate Account – Real Estate Fund (1)

_____% Vanguard VIF Real Estate Index Portfolio

Separate Account – Retirement Funds (12)

_____% Mutual of America Retirement Income Fund
_____% Mutual of America 2010 Retirement Fund
_____% Mutual of America 2015 Retirement Fund
_____% Mutual of America 2020 Retirement Fund
_____% Mutual of America 2025 Retirement Fund
_____% Mutual of America 2030 Retirement Fund
_____% Mutual of America 2035 Retirement Fund
_____% Mutual of America 2040 Retirement Fund
_____% Mutual of America 2045 Retirement Fund
_____% Mutual of America 2050 Retirement Fund
_____% Mutual of America 2055 Retirement Fund
_____% Mutual of America 2060 Retirement Fund

Separate Account – Balanced Funds (3)

_____% Mutual of America Composite Fund
_____% Fidelity® VIP Asset Manager Portfolio
_____% Calvert VP SRI Balanced Portfolio

SECTION 3 - BENEFICIARY DESIGNATIONS

If you are married, you must name your Eligible Spouse (as defined in the Plan and federal law) as your only beneficiary unless your Eligible Spouse signs the Spouse's Waiver of Death Benefits below in the presence of a Plan (employer) representative or a notary public after you designate the beneficiaries you wish below. Whenever you want to change your beneficiaries, your Eligible Spouse must sign a new waiver unless you name your Eligible Spouse as your only beneficiary. If you are younger than 35 when you name alternative beneficiaries with the consent of your Eligible Spouse, your beneficiary designation will automatically terminate when you attain age 35 and your Eligible Spouse will be your beneficiary unless you again designate alternative beneficiaries with a new signed waiver from your Eligible Spouse.

If you are unmarried, you may name any beneficiaries you wish. If you marry in the future, your beneficiary designation under the retirement plan will be automatically voided. At that time, you should complete Mutual of America's "Beneficiary Designation" form and follow the instructions applicable to married participants.

In the event of your death, and subject to the Eligible Spouse Waiver requirements, the total value of your account will be paid to the person or persons you name as your primary beneficiary. If no one you have named as a primary beneficiary survives you, the person(s) you name as your secondary beneficiary will receive the death benefit. If there is no living designated beneficiary at your death, the amount payable will be paid to the first surviving class of the following: (a) your surviving spouse (as determined under state law), (b) your surviving children in equal shares, (c) your surviving parents in equal shares, (d) your surviving brothers and sisters in equal shares, or (e) the executors or administrators of your estate.

If you name more than one primary beneficiary, or more than one secondary beneficiary, the death benefit will be paid in equal shares to the primary beneficiaries who survive you, or if none, to the secondary beneficiaries who survive you, unless you show below the percentage you want each of them to receive. If you specify percentages you want each beneficiary to receive, be sure your percentages for all beneficiaries in each beneficiary type total 100%.

Name your primary and secondary beneficiaries in the space provided. If you need more space, attach a page showing for each beneficiary the information asked for below.

Beneficiary Type: [X] Primary **Relationship:** [ ] Spouse [ ] Child [ ] Parent [ ] Estate [ ] Other	**Beneficiary Type:** [ ] Primary [ ] Secondary **Relationship:** [ ] Spouse [ ] Child [ ] Parent [ ] Estate [ ] Other
FULL NAME First Initial Last	FULL NAME First Initial Last
DATE OF BIRTH / / | SOCIAL SECURITY # | TELEPHONE NUMBER	DATE OF BIRTH / / | SOCIAL SECURITY # | TELEPHONE NUMBER
ADDRESS Street	ADDRESS Street
City State Zip Code	City State Zip Code
IF FOREIGN RESIDENT Province Country | BENEFIT PERCENT %	IF FOREIGN RESIDENT Province Country | BENEFIT PERCENT %

Beneficiary Type: [ ] Primary [ ] Secondary **Relationship:** [ ] Spouse [ ] Child [ ] Parent [ ] Estate [ ] Other	**Beneficiary Type:** [ ] Primary [ ] Secondary **Relationship:** [ ] Spouse [ ] Child [ ] Parent [ ] Estate [ ] Other
FULL NAME First Initial Last	FULL NAME First Initial Last
DATE OF BIRTH / / | SOCIAL SECURITY # | TELEPHONE NUMBER	DATE OF BIRTH / / | SOCIAL SECURITY # | TELEPHONE NUMBER
ADDRESS Street	ADDRESS Street
City State Zip Code	City State Zip Code
IF FOREIGN RESIDENT Province Country | BENEFIT PERCENT %	IF FOREIGN RESIDENT Province Country | BENEFIT PERCENT %

Are you married? [ ] Yes [ ] No

NOTE: Mutual of America and or your employer may require evidence that you are not married if their records indicate that you are or were previously married.

If you are married and have <u>not</u> designated your spouse as primary beneficiary, the Spouse's Waiver Section below must be completed.

SPOUSE'S WAIVER (Witnessed by a Notary Public or Authorized Representative of Employer)

My spouse is a participant in a Mutual of America Thrift Plan under which I am entitled to be the beneficiary. As the beneficiary, I would receive a death benefit after my spouse's death. However, I agree to waive my right to be the beneficiary. I agree to let my spouse designate the beneficiary or beneficiaries named on this form.

Spouse's Name _____ Date of Birth _____

Signature of Spouse _____ Date _____

Signature and Seal of Notary Public or Signature of Authorized Representative _____ Date _____

Mutual of America employees are not authorized to sign as Plan representatives.

Notary's acknowledgment may be added below:

SECTION 4 - STATEMENT AND SIGNATURE

I have read the current prospectus and other materials describing the plan and after careful consideration I have found the plan to be suitable for my financial needs. Therefore, I elect to participate in the Thrift Plan.

EMPLOYEE'S SIGNATURE	DATE

SECTION 5 - AUTHORIZATION TO RECEIVE ELECTRONIC DOCUMENTS (eDocuments)

Consent to Receive Electronic Documents

Sign Up and We'll Waive Your Monthly Participant Charges

I request that Mutual of America deliver to me through its Internet website, for each product that I now (or in the future) own, or under which I participate through my employer, the following documents: prospectuses (and/or brochures, depending on the Mutual of America product) and supplements to prospectuses and brochures; semi-annual and annual reports, which contain financial and other information; quarterly account statements; confirmation statements for account transactions; proxy statements and related voting materials; privacy notices, including initial, annual and opt-in or opt-out notices; regulatory fee disclosures; and any other documents required to be delivered to me by Mutual of America under federal or state laws.

I acknowledge that I will continue to receive paper copies of certain of these documents until they become available online or if electronic delivery under this agreement is not permitted by law. An added benefit of my consenting to receive the above referenced material electronically is that the monthly participant charge ($2.00 per month or 1/12 of 1% if the account balance is less than $2,400) will be waived for each month. I must consent to receive eDocuments by 6:00 p.m. Eastern Time of the last business day of the month.

I understand that Mutual of America will send an email notice to the email address I have provided each time one of these documents is available to me online. I also understand that I will need to log in to Mutual of America's website to view documents online and to make any necessary updates to my email address. I understand that if I would like to receive a paper copy of any of these documents, I should call Mutual of America at 1-800-468-3785, and Mutual of America will provide a copy of the requested documents free of charge. I agree that Mutual of America in the future may change its method of providing notice of available documents, so long as Mutual of America gives me advance notice of each planned change, and may from time to time change the location on its website of certain of the available documents.

My consent to receive various documents through Mutual of America's website will continue to be effective until:

1) I revoke my consent, at any time without charge (subject to the monthly participant charge described above), either online or by calling Mutual of America at 1-800-468-3785 and instructing a customer service representative to revoke my consent;

2) my consent is automatically revoked and the monthly participant charge will be applicable when email sent to the email address I have given is returned to Mutual of America as undeliverable;

3) Mutual of America for any reason discontinues providing documents online; or

4) my consent is automatically revoked when Mutual of America makes a material change in the hardware or software required to view documents online that interferes with my ability to view those documents.

I acknowledge that the online service provider I utilize for access to the Internet may charge me a fee for the time required to view Mutual of America's documents online or for other services.

My email address for receiving notices of documents available online, which I may update from time to time, is:

_____

PLEASE TYPE OR PRINT YOUR EMAIL ADDRESS CLEARLY

Printed Name: _____

Signature: _____ Date: ___/___/___

(EMPLOYER NAME)

403(b)
SALARY REDUCTION AGREEMENT

XXX-XX-___ ___ ___ ___

EMPLOYEE NAME

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER

The Plan has been explained to me, and I have been given a Summary Plan Description. I understand that I may voluntarily choose to have my pay reduced for contributions to the Plan.

ELECTION TO CONTRIBUTE

I elect to designate my contributions as Traditional Pre-Tax Contributions and/or Designated Roth Contributions (after-tax contributions) as follows:

- *Pre-Tax Contributions*: I elect to contribute _____% of my pay, and I authorize my employer to deduct that amount each pay period.
- *Designated Roth Contributions (after tax)*: I elect to contribute _____% of my pay, and I authorize my employer to deduct that amount each pay period.

I am aware that:

1) My contribution may be reduced in order to comply with Federal tax rules and limits, including any higher limits that apply to participants age 50 or older.
2) This election will take effect with the first pay period beginning on or after the first day of the next month, or as soon as it is administratively feasible for my employer to begin deductions from my pay after I file this Salary Reduction Agreement with my employer. I may stop or change my election for future pay periods by giving my employer written notice, which notice will take effect as soon as administratively feasible.
3) My contributions and earnings cannot be withdrawn or paid until I attain age 59½ or upon my death, disability, or termination of employment. My contributions may be available for withdrawal in the event of serious financial hardship (according to the Plan and IRS rules).
4) Any portion of my contributions that I elect to be Designated Roth Contributions are after-tax and will be subject to regular income tax as part of my regular taxable pay. Distributions of Designated Roth Contributions will not be taxable when distributed from the Plan, but distributions of earnings may be subject to tax or penalty if not qualified. A qualified distribution is a distribution made (a) at least five years after I began Designated Roth Contributions and (b) after I have attained age 59 ½ , become disabled or die.
5) Any election to treat all or part of my contribution as Designated Roth Contributions is irrevocable once the contributions are deducted from my pay.
6) **This election generally applies to all compensation payments that I receive, as described in my employer's Plan document.**

EMPLOYEE SIGNATURE — DATE

EMPLOYER REPRESENTATIVE — DATE RECEIVED

ELECTION NOT TO CONTRIBUTE

I do not wish to contribute to the Plan at this time. I understand that if the Plan provides for matching employer contributions, I will not be entitled to such contributions during the time I am not contributing. I also understand that I may elect to contribute in the future by completing a Salary Reduction Agreement and an Enrollment Form and filing them with my employer.

EMPLOYEE SIGNATURE — DATE

EMPLOYER REPRESENTATIVE — DATE RECEIVED

NOTE TO EMPLOYERS

THIS FORM SHOULD BE RETAINED WITH THE EMPLOYER'S RECORDS OF THE PLAN.

EMPLOYERS SHOULD REVIEW THIS SAMPLE PAYROLL AUTHORIZATION FORM WITH LEGAL COUNSEL IN PARTICULAR REGARDING ANY APPLICABLE STATE LAW THAT MAY AFFECT THIS DOCUMENT.