SALARY DEFERRAL ENROLLMENT/CHANGE FORM

Name of Employer/Plan _____

Please check one of the following: ☐ New plan enrollment ☐ Changes to existing election(s)

1 Employee Information (*Please type or print clearly)*

First name _____ MI ____ Last _____ SSN ☐☐☐-☐☐-☐☐☐☐

Residence address (physical address required — no P.O. boxes) _____ City _____ State ____ ZIP _____-____

Email Address _____ Mobile Number _____ Country of Citizenship _____

Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐ Date of hire (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐ ☐ Married ☐ Single Marital Status

2 Employee Contributions - This salary deferral agreement remains in effect until I revoke or modify it. Modifications to the Agreement are permitted when the plan administrator allows it .

Regular Compensation. My total Compensation *excluding* bonuses and other irregular payments.

☐ I authorize my employer to withhold from my wages each pay period:
Pre-tax contributions of _____% OR $_____

☐ I authorize my employer to withhold from my wages each pay period:
After-tax ROTH contributions of _____% OR $_____

Bonus/Commissions or other irregular payments.
(If separate election is not made, the election for Regular Compensation will apply.)

☐ I do not wish to have deferrals withheld from my Bonus/Commissions or other irregular payments.

☐ I authorize my employer to withhold from my Bonus/Commissions or other irregular payments:
Pre-tax contributions of _____% OR $_____

☐ I authorize my employer to withhold from my Bonus/Commissions or other irregular payments:
After-tax ROTH contributions of _____% OR $_____

3 Decline Deferral - ☐ I elect to have none of my salary deferred into the plan at this time.

Duty to review pay records. I understand I have a duty to review my pay records (pay stub, etc.) to confirm the salary reduction amount. I have a duty to inform the Plan Administrator of any discrepancy found. Failure to report any withholding errors for any payroll to which my Salary Reduction Agreement applies by the cut-off date for the following payroll period will be considered acceptance of the amount actually withheld (including zero).

4 Effective date of change: _____

Authorization

Signature of Employee _____ Date _____ Signature of Plan Sponsor _____ Date _____

PLEASE RETURN THIS FORM TO THE PLAN SPONSOR