

Participant Enrollment/Investment Election Form
Ellenville Regional Hospital Voluntary 403(b) Plan

274112

PARTICIPANT INFORMATION: (Please Print Information Clearly)

Name: _____ Date of Birth: ____/____/____
Street: _____ City: _____ State: _____ Zip: _____
Social Security Number: _____ Married: _____ Single: _____ Date of Hire: ____/____/____

CONTRIBUTION ELECTION

Elective Deferrals

- ☐ PRE-TAX CONTRIBUTIONS: I elect to participate and contribute _____% or \$_____ of compensation per pay period on a pre-tax basis, as indexed.
- ☐ I elect not to make *elective deferrals* until further notice. I understand that if I do not participate now, or discontinue participation, I must wait until the next available enrollment date.

Catch-up Contributions

If you will be 50 years old or older as of the last day of the calendar year and otherwise contribute the maximum allowable amount to the Plan, you are entitled to make additional "catch-up" contributions per your Plan's Summary Plan Description. See the Plan Administrator for more details.

INVESTMENT ELECTION

I authorize all contributions to be invested as follows.

Individual Investments

New Contributions must be entered as whole percentages and total 100%.

Investment Name	Ticker	Type	ID	New Contributions
MetLife Stable Value 32958*	9NGIC	Stable Value	9N	_____%
BlackRock High Yield Inst'l	BHYIX	Bond	XQ	_____%
BlackRock Infl Protected Bd I	BPRIX	Bond	TE	_____%
MetWest Total Return Bond I	MWTIX	Bond	PG	_____%
American Funds Am Balancd R6	RLBGX	Balanced	GM	_____%
T. Rowe Price Ret'mt 2010 I	TRPUX	Balanced	LQ	_____%
T. Rowe Price Ret'mt 2015 I	TRUBX	Balanced	LR	_____%
T. Rowe Price Ret'mt 2020 I	TRDBX	Balanced	LS	_____%
T. Rowe Price Ret'mt 2025 I	TREHX	Balanced	LT	_____%
T. Rowe Price Ret'mt 2030 I	TRFHX	Balanced	LU	_____%
T. Rowe Price Ret'mt 2035 I	TRFJX	Balanced	LV	_____%
T. Rowe Price Ret'mt 2040 I	TRHDX	Balanced	LW	_____%
T. Rowe Price Ret'mt 2045 I	TRIKX	Balanced	LX	_____%
T. Rowe Price Ret'mt 2050 I	TRJLX	Balanced	LY	_____%
T. Rowe Price Ret'mt 2055 I	TRJMX	Balanced	LZ	_____%
T. Rowe Price Ret'mt 2060 I	TRLNX	Balanced	M1	_____%
T. Rowe Price Ret'mt 2065 I	TRMOX	Balanced	M2	_____%
DFA US Sm Cap Growth Portfolio	DSCGX	Equity	DT	_____%
EV Parametric Emrg Mrkt I	EIEMX	Equity	XY	_____%
Harbor International Core Ret	HAORX	Equity	B3	_____%
JH Disciplined Val Mid Cap R6	JVMRX	Equity	T9	_____%
MFS Value R6	MEIKX	Equity	XZ	_____%
Vanguard 500 Index Admiral	VFIAX	Equity	UG	_____%
Vanguard Growth Index Admiral	VIGAX	Equity	NP	_____%

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Investment Name	Ticker	Type	ID	New Contributions
Vanguard Mid-Cap Gr Index Adm	VMGMX	Equity	YX	_____ %
Vanguard Mid-Cap Index Admiral	VIMAX	Equity	UJ	_____ %
Vanguard Small-Cap Index Adm	VSMAX	Equity	9R	_____ %
Virtus Duff & Phelps RE Secur	VRREX	Equity	ZB	_____ %

Note: Funds marked with an asterisk (*) report investment returns on a calendar quarter basis.

SIGNATURES

Participant Signature

Date

For more information on your Plan, call the Voice Response System at 800-530-1272 or access the Internet site at u.bpas.com. You can also speak directly to a Participant Service Center representative by calling 866-401-5272, Monday-Friday, 8:00am-8:00pm EST.

Instructions for Designation or Change of Beneficiary

Your Personal Information

- Please fill in all blank boxes in the designated area of the form.

Your Marital Status

- Please check box A, B or C as indicated. If you check box A or B, please sign at bottom of the page and return to your employer, after completing the Beneficiary information.
- If you check box C, (married and wish to designate a primary beneficiary other than your spouse), both **you and your spouse** must sign the waiver on the second page of the Beneficiary Election Form, and have your signatures **validated** by a Notary Public.

PLEASE NOTE: If you are re-married and do not complete a new Beneficiary Form, your new spouse may not be eligible for death benefits until the first anniversary of your new marriage.

Primary Beneficiaries

- If only one person is listed in this section and no percentage is given, 100% of the death benefit, if any, will be provided to named person.
- The total of all “% of shares” must be no more or less than 100 percent.
- If more than one person is listed and no percentage of share is indicated, all participants will receive equal amounts.
- If the beneficiary is not related to you, show the relationship as “Friend”.
- If you wish to name your estate, insert “Estate” in the Name box.
- If you wish to designate a trust, insert the name of the trustee and trust in the blank space provided using language substantially as follows:
To [bank name] as Trustee, or its successor Trustee, of the John Doe Trust dated the 14th day of April, 1998, including any amendments.
- To designate all or future children, you may enter “My children living at my death” in the blank space provided.

Secondary Beneficiaries

- If, upon your death there are no Primary Beneficiaries living, the Secondary Beneficiaries will receive death benefits, if any, from the Plan.
- The above instructions for Primary Beneficiaries are also applicable to Secondary Beneficiaries.

Election to Waive the Pre-Retirement Survivor Benefit (Page 2)

- If you checked box C (Marital Status), you must complete page 2 of this form. The signatures must be witnessed and validated by a Notary Public.

Once the form has been completed, please return to your Human Resource Representative

BENEFICIARY ELECTION FORM**Your Personal Information**

Participant Name		Social Security #	
Street Address			
City		State	Zip
Employer			
Plan Name			

Your Marital Status

Please **check one** of the three following boxes below and name primary and secondary beneficiaries:

- ☐ A. I am **not married**. I designate the following person(s) to receive my death benefits, if any, from the plan. If I become married, this form automatically ceases to apply and I should file a new Beneficiary Election Form.
- ☐ B. I **am married**, and I designate my spouse named below as sole primary beneficiary to receive my death benefits, if any, from the plan. If I re-marry, I will need to fill out a new form to designate my new spouse to receive my death benefits, if any, from the plan
- ☐ C. I **am married**, and I wish to designate **someone other than my spouse** as a primary beneficiary to receive my death benefits, if any, from the plan. You **MUST** Complete Election to Waive the Pre-Retirement Survivor Benefit.

Primary Beneficiaries

Name			
Address			
Relationship			
Date of Birth			
Social Security #			
% Of Share			

Secondary Beneficiaries

Name			
Address			
Relationship			
Date of Birth			
Social Security #			
% Of Share			

If I have designated more than one Primary Beneficiary, the said amount(s) shall be equally divided among my Primary Beneficiaries who are living at the time of my death unless I specify otherwise on this form. If, upon my death, there is no Primary Beneficiary living, and if I have named more than one Secondary Beneficiary, the said amount(s) shall be equally divided among my Contingent Beneficiaries who are living at the time of my death unless I specify otherwise on this form. The execution of this form and delivery thereof to the Plan Administrator revokes all prior designations of Beneficiaries that I may have made.

Participant Signature _____ Date _____

BENEFICIARY ELECTION FORM

Participant Name		Social Security #	
Employer			
Plan Name			

Election to Waive the Pre-Retirement Survivor Benefit

Must complete if checked box C
Notary Public must witness signatures

Participant Waiver:

I acknowledge that I have been informed that if I should die prior to my retirement, my Spouse and I have the right to have my entire vested account balance in the plan paid to my Spouse; that I have the right to waive the designation of my Spouse as beneficiary of my death benefit **only** if my spouse consents to revoke such waiver.

I hereby waive my right to have my Spouse as Primary Beneficiary of the Pre-Retirement Death Benefit payable under the Plan.

Participant Printed Name

Participant Signature

Date***Spouse's Consent:***

I hereby approve of, and consent to, the Beneficiary Designation adopted by my Spouse as provided above. I understand that I am entitled to receive a Spouse's Benefit under the Plan unless I consent to a different Beneficiary Designation. I also understand that the above designation has the effect of causing the Death Benefit under the Plan to be paid to another beneficiary. I further understand that my Spouse may not change the Primary Beneficiary Designation without first obtaining my written consent.

Spouse's Printed Name

Spouse's Signature

Date***Notary Public Validation:***

State of _____, County of _____

On this _____ day of _____ in the year of _____

The above persons have appeared before me are personally known by me (or have provided proof of identification) and have signed in my presence this Participant Waiver and Spouse's Consent.

Notary Public Printed Name

Notary Public Printed Signature

Date

Once the form has been completed, please return to your Human Resource Representative

SALARY REDUCTION AGREEMENT

Instructions

This Salary Reduction Agreement must be completed and submitted to your employer.

Name of Employer: _____

Plan Type: π 403(b) π 401(k) π 457(b) π Other _____

SECTION A. Participant Information (Please print)

Participant's Full Name: _____

Social Security No. _____ - _____ - _____ Date of Birth: ____/____/____ Date of Hire: ____/____/____

Daytime Telephone: () _____

SECTION B. Salary Reduction Amount

I agree to reduce my eligible compensation by \$ _____ or _____ % each pay period as pre-tax salary deferral following the
next pay period, or effective on _____.

The employer will reduce your pay by the amount, per pay period, indicated above and send this amount to the 403(b), 401(k), 401(a), or 457 plan/program. The first payroll deduction will begin as soon as administratively possible after the form is completed and submitted in good order. While employment continues, this agreement legally binds you and the employer for amounts deferred while it is in effect.

SECTION C. Catch-up-Contributions*

I agree to reduce my eligible compensation by \$ _____ or _____ % each pay period as pre-tax salary deferral not to exceed the maximum

*Where an employee is eligible for both the age 50 catch-up and the special section 403(b) 15-year catch-up limitations in the same year the 15 year catch-up provision must be applied first to any deferrals exceeding the annual 402(g) limit. Any deferral contributions above the annual limit and 15-year catch-up limit (if applicable) would be treated as age 50 catch-up contributions.

SECTION D. Signature

I understand that:

- a new agreement must be submitted to change or stop my deductions;
- it is my responsibility to inform my employer of all elective contributions made to other plans with a previous or other employer;
- this agreement will apply only to amounts available to me and will not apply to amounts earned after this agreement is terminated;
- this agreement may not permit aggregate amount of salary deferral contributions under the plan/program, which when added to elective deferrals made to other plans (i.e. 403(b), 457(b), 401(a), or 401(k) plans), may not exceed the limit in effect for that year.

_____/_____/_____
Participant's Signature Date

_____/_____/_____
Employer Representative's Signature Date

Participant – Print Name

Employer Representative – Print Name