

# Askar Management Group, LLC 401(k) Plan Features and Highlights

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Read these highlights to learn more about your Plan. If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

## About the 401(k) Plan

A 401(k) plan is a retirement savings plan designed to allow eligible employees to supplement any existing retirement and pension benefits by saving and investing through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn.

## Eligibility Requirements

### Employee Before Tax

To enroll in the Plan, employees must meet the following criteria:

- Age 21 or older
- Completed 90 day(s) of service

Eligible employees may enroll each month.

### Safe Harbor Employer Matching Contribution

To enroll in the Plan, employees must meet the following criteria:

- Age 21 or older
- Completed 90 day(s) of service

Eligible employees may enroll each month.

### Profit Sharing

To enroll in the Plan, employees must meet the following criteria:

- Age 21 or older
- Completed 90 day(s) of service

Eligible employees may enroll each month.

Please contact your Plan Administrator for information regarding excluded employees.

## Enrollment

You may enroll by using the online enrollment option available at [empowermyretirement.com](http://empowermyretirement.com).

## Contribution Limits

### Before Tax

In 2021, the Before Tax amount is between 1% and 100% of your compensation or \$19,500.00, whichever is less.

Participants turning age 50 or older in 2021, may contribute an additional \$6,500.00.

### Roth

The Roth option will give you the flexibility to designate all or part of your 401(k) elective deferrals as Roth contributions.

Roth contributions are made with after-tax dollars, as opposed to the pre-tax dollars you contribute to a traditional 401(k). In other words, with the Roth option, you've already paid taxes on money you contribute. With the traditional 401(k), your contribution is

made on a pre-tax basis and you pay taxes only when you take a distribution.

## Employer Contributions

### Safe Harbor Employer Matching Contribution

Your plan provides for a match of 100% of deferrals up to 3% of compensation plus 50% of deferrals on 3 to 5% of compensation.

### Profit Sharing

Your Plan may provide for a profit sharing contribution in an amount to be determined by your employer.

To be eligible for the profit sharing contribution into the Plan, employees must meet the following criteria:

- Employed on the last day of the Plan year and completed 1000 hours or more

## Vesting Schedule

Vesting refers to the percentage of your account you are entitled to receive upon the occurrence of a distributable event. The value of your contributions to the Plan and any earnings they generate are always 100% vested (including rollovers from previous employers).

The employer safe harbor match contribution is immediately 100% vested.

The value of employer profit-sharing contributions to the Plan, and any earnings they generate, are vested as follows:

Years of Service	Vested Percentage of Employer Contributions
0 - 2 Year(s)	0%
2 - 3 Year(s)	20%
3 - 4 Year(s)	40%
4 - 5 Year(s)	60%
5 - 6 Year(s)	80%
6 Years and over	100%

## Investment Options<sup>1</sup>

A wide array of investment options are available through your Plan. Please review the Plan's Notice of Investment Returns & Fee Comparison for information on the investment options at [empowermyretirement.com](http://empowermyretirement.com). Once you have enrolled, investment option information is also available through the Web site at [empowermyretirement.com](http://empowermyretirement.com) or call the Voice Response System toll free at 1-800-338-4015. The Web site and the Voice Response System are available to you 24 hours a day, 7 days a week.<sup>2</sup>

<sup>1</sup>All information contained on the Web site, in prospectuses and other investment option documents is offered in English. Please have this information translated for your understanding.

<sup>2</sup>Access to the Voice Response System and the Web site may be limited or unavailable during periods of peak demand, market volatility, systems upgrades and maintenance, or other reasons. The account owner is responsible for keeping the assigned PIN confidential. Please contact a client service representative immediately if you suspect any unauthorized use.

## Transfers and Allocation Changes

Use your Personal Identification Number (PIN) and Username to access the Web site or you can use your Social Security number and PIN to access the Voice Response System. You can move all or a portion of your existing balances between investment options (subject to Plan rules) and change how your payroll contributions are invested.

## Rollovers

Only Plan Administrator approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the Plan. Some plans may only allow rollovers from other 401(k) plans. Distributions you receive prior to age 59 1/2 may be subject to the 10% early withdrawal federal tax penalty.

## Withdrawals

Qualifying distribution events are as follows:

- Retirement
- Permanent disability
- Financial hardship (as defined by the Internal Revenue Code and your Plan's provisions)
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Attainment of age 59 1/2
- Death (your beneficiary receives your benefits)

Ordinary income tax will apply to each distribution. Distributions received prior to age 59 1/2 may also be assessed a 10% early withdrawal federal tax penalty. Refer to your Summary Plan Description for more information about distributions.

## Plan Fees

Please review the Plan's Notice of Investment Returns & Fee Comparison for information on Plan fees and expenses.

## Loans

Your Plan allows you to borrow the lesser of \$50,000.00 or 50% of your eligible total vested account balance. The minimum loan amount is \$1000.00 and you have up to 60 months to repay your hardship loan.

## How do I get more information?

Visit the Web site at [empowermyretirement.com](http://empowermyretirement.com) or call the Voice Response System, toll free at 1-800-338-4015 for more information. The Web site provides information regarding your Plan, as well as financial education information, financial calculators and other tools to help you manage your account.

Securities, when offered, are offered through GWFS Equities, Inc. and/or other broker dealers. GWFS Equities, Inc. is a wholly owned subsidiary of Great-West Life & Annuity Insurance Company and an affiliate of FASCore, LLC (FASCore Administrators, LLC in California) and Great-West Life & Annuity Insurance Company of New York, New York, New York. Empower Retirement refers to products and services provided by Great-West Life & Annuity Insurance Company, FASCore, LLC (FASCore Administrators, LLC in California), Great-West Life & Annuity Insurance Company of New York, New York, New York and their subsidiaries and affiliates. Great-West Life & Annuity Insurance Company is not licensed to conduct business in New York. Insurance products and related services are sold in New York by its subsidiary, Great-West Life & Annuity Insurance Company of New York. Other products and services may be sold in New York by FASCore, LLC.

The Plan information contained in this document was provided by the Plan's third party administrator. Empower Retirement is not responsible for any content provided by the Plan's third party administrator.

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## Participant Enrollment 401(k) Plan

Askar Management Group, LLC 401(k) Plan

370172-01

### Participant Information

Last Name		First Name		MI	Social Security Number	
(The name provided MUST match the name on file with Service Provider.)						
Mailing Address						
City		State	Zip Code		E-Mail Address	
( ) ( )		( )	( ) ( )		( ) ( ) ( ) ( ) ( ) ( )	
Home Phone		Work Phone				
( ) ( ) ( ) ( ) ( ) ( )		( ) ( ) ( ) ( ) ( ) ( )				
<input type="checkbox"/> Check box if you prefer to receive quarterly account statements in Spanish.						

Do you have a retirement savings account with a previous employer or an IRA? ☐ Yes ☐ No

Would you like help consolidating your other retirement accounts into your account with Empower Retirement?\* ☐ Yes, I would like a representative to call me at phone # \_\_\_\_\_ to review my options and assist me with the process. The best time to call is \_\_\_\_\_ to \_\_\_\_\_ A.M./P.M. (circle one - available 6 a.m. to 8 p.m. Mountain time). \*Rollovers are subject to your Plan's provisions.

### Payroll Information

- ☐ I elect to contribute \$ \_\_\_\_\_ or \_\_\_\_\_% (do not complete both) (up to \$19,500.00 or 1% - 100%) per pay period of my compensation as Before Tax contributions to the 401(k) Plan until such time as I revoke or amend my election.
- ☐ I elect to contribute \$ \_\_\_\_\_ or \_\_\_\_\_% (do not complete both) (up to \$19,500.00 or 1% - 100%) per pay period of my compensation as Roth contributions to the 401(k) Plan until such time as I revoke or amend my election.

Note: The total of your before-tax and Roth deferrals cannot exceed \$19,500.00. If I am 50 years of age or older and I am eligible for a catch-up contribution, I understand I may exceed this total.

- ☐ I decline to make contributions to the Plan at this time.

Payroll Effective Date: \_\_\_\_\_  
Mo Day Year

Date of Hire: \_\_\_\_\_  
Mo Day Year

### Age 50 Catch-Up Election

The total before-tax and Roth Age 50 Catch-Up amount cannot exceed \$6,500.00 of my eligible compensation in the 2021 tax year. I must be age 50 or older during this calendar year and I must be currently deferring the maximum amount allowable under the Internal Revenue Code and applicable regulations and/or my Plan. If I stop my deferrals and/or do not defer the maximum amount during this calendar year, the Age 50 Catch-Up amount I have elected to contribute will not be considered a Catch-Up deferral. The Catch-Up contributions will be allocated in the same manner as my regular contributions.

### To be completed by Human Resources

Division Name \_\_\_\_\_ Division Number \_\_\_\_\_

### Investment Option Information (applies to all contributions) - Please refer to your enrollment packet for investment descriptions.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure documents for more information.

### See below for Participation Agreement and Required Signatures

INVESTMENT OPTION			INVESTMENT OPTION		
NAME	TICKER CODE	%	NAME	TICKER CODE	%
Great-West Lifetime 2015 Fund Svc.....	MXLZX MX15A1	_____	Great-West Small Cap Value Inv.....	MXLSX MXLSS	_____
Great-West Lifetime 2025 Fund Svc.....	MXFLX MX25A1	_____	PGIM QMA Small-Cap Value R.....	TSVRX TSVRX	_____
Great-West Lifetime 2035 Fund Svc.....	MXLLX MX35A1	_____	BNY Mellon Opp Midcap Value A.....	DMCVX DMCVX	_____
Great-West Lifetime 2045 Fund Svc.....	MXRLX MX45A1	_____	Eaton Vance Atlanta Capital SMID-Cap A.....	EAASX EAASX	_____
Great-West Lifetime 2055 Fund Svc.....	MXXLX MX55A1	_____	Victory Sycamore Established Value A.....	VETAX VETAX	_____
Aberdeen Emerging Markets A.....	GEGAX GEGAX1	_____	Fidelity Advisor Mega Cap Stock A.....	FGTAX FGTAX	_____
Great-West International Value Inv.....	MXIVX MXIVX	_____	Great-West S&P 500 Index Fund Inv.....	MXVIX MXIN5	_____
MFS Global Equity R3.....	MWEHX MWEHX	_____	JPMorgan Equity Income A.....	OIEIX OIEIX	_____

Last Name			First Name	M.I.	Social Security Number	Number	
NAME	TICKER	CODE	%	NAME	TICKER	CODE	%
Oakmark International Service.....	OARIX	OARIX	_____	Wells Fargo Prem Lg Co Gr A.....	EKJAX	EKJAX	_____
Invesco Oppenheimer Int'l Growth A.....	OIGAX	OIGAX	_____	Delaware Ivy High Income Y.....	WHIYX	WHIYX	_____
Delaware Ivy Science And Technology Y.....	WSTYX	WSTYX	_____	Metropolitan West Total Re Bd Admin Cl.....	MWTNX	MWTNX	_____
PIMCO Commodity Real Ret Strat A.....	PCRAX	PCRAX1	_____	PIMCO Real Return A.....	PRTNX	PRTNX	_____
T. Rowe Price Global Real Estate Adv.....	PAGEX	PAGEX	_____	Templeton Global Total Return A.....	TGTRX	TGTRX	_____
Franklin Small Cap Growth A.....	FSGRX	FSGRX	_____	Key Guaranteed Portfolio Fund.....	N/A	KGPF	_____
MUST INDICATE WHOLE PERCENTAGES							=100%

### Participation Agreement

**Withdrawal Restrictions** - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

**Investment Options** - I understand that by signing and submitting this Participant Enrollment form for processing, I am requesting to have investment options established under the Plan as specified in the Investment Option Information section. I understand and agree that this account is subject to the terms of the Plan Document. I understand and acknowledge that all payments and account values, when based on the experience of the investment options, may not be guaranteed and may fluctuate, and, upon redemption, shares may be worth more or less than their original cost. I acknowledge that investment option information, including prospectuses, disclosure documents and Fund Profile sheets, have been made available to me and I understand the risks of investing.

**Compliance With Plan Document and/or the Code** - I agree that my employer or Plan Administrator may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

**Incomplete Forms** - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option selected by the Plan. If no default investment option is selected, funds will be returned to the payor as required by law. Once my account has been established, I understand that I must call 1-800-338-4015 or access the Web site in order to transfer monies from the default investment option. Also, I understand all contributions received after my account is established will be applied to the investment options I have most recently selected.

**Account Corrections** - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will be only processed from the date of notification forward and not on a retroactive basis.

**Required Signature(s)** - I have completed, understand and agree to all pages of this Participant Enrollment form. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at:  
<http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>.

#### Participant Signature

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

#### Date

Participant forward to Plan Administrator/Trustee  
**Plan Administrator** forward to Service Provider at:  
 Empower Retirement  
 PO Box 173764  
 Denver, CO 80217-3764

#### Express Address:

8515 E. Orchard Road, Greenwood Village, CO 80111  
**Phone#:** 1-800-338-4015

We will not accept hand delivered forms at Express Mail addresses.

#### Authorized Plan Administrator/Trustee

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

#### Date

#### Print Full Name

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# Paycheck Contribution Election 401(k) Plan

**Askar Management Group, LLC 401(k) Plan**

**370172-01**

Use black or blue ink when completing this form. For questions regarding this form, visit the Web site at [empowermyretirement.com](http://empowermyretirement.com) or contact Service Provider at 1-800-338-4015.

## A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension \_\_\_\_\_

			-			-					
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Social Security Number (Must provide all 9 digits)

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

M.I. \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

(The name provided MUST match the name on file with Service Provider.)

( ) \_\_\_\_\_

Alternate Phone Number \_\_\_\_\_

Division \_\_\_\_\_

I have a retirement savings account with a previous employer or an IRA. ☐ Yes or ☐ No

I would like help consolidating my other retirement accounts into my account with Empower Retirement.\* ☐ Yes, I would like a representative to call me at phone # \_\_\_\_\_ - \_\_\_\_\_ to review my options and assist me with the process. The best time to call is \_\_\_\_\_ to \_\_\_\_\_ A.M./P.M. (circle one - available 6 a.m. to 8 p.m. Mountain time). \*Rollovers are subject to my Plan's provisions.

## B Payroll Election(s)

### Paycheck Contribution Election (Payroll Deductions)

Select One: ☐ Start ☐ Restart ☐ Change ☐ Stop

I elect to contribute to the Plan the following of my eligible compensation indicated below (per pay period):

☐ Before Tax Contributions \$ \_\_\_\_\_ or \_\_\_\_\_ % (do not complete both) (up to \$19,500.00 or 1% - 100%)

☐ Roth Contributions \$ \_\_\_\_\_ or \_\_\_\_\_ % (do not complete both) (up to \$19,500.00 or 1% - 100%)

Payroll Effective Date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Hire (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

The total annual before-tax and Roth contributions cannot exceed \$19,500.00 of my eligible compensation in the 2021 tax year.

### Age 50 Catch-Up Election

I elect to contribute to the Plan additional Age 50 Catch-Up amounts of my eligible compensation as indicated below (per pay period):

Payroll Effective Date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

The total before-tax and Roth Age 50 Catch-Up amount cannot exceed \$6,500.00 of my eligible compensation in the 2021 tax year. I must be age 50 or older during this calendar year and I must be currently deferring the maximum amount allowable under the Internal Revenue Code and applicable regulations and/or my Plan. If I stop my deferrals and/or do not defer the maximum amount during this calendar year, the Age 50 Catch-Up amount I have elected to contribute will not be considered a Catch-Up deferral. The Catch-Up contributions will be allocated in the same manner as my regular contributions.

☐ I elect to cancel my Catch-Up contribution election.

## C Signatures and Consent (Signatures must be on the lines provided.)

### Participant Consent (Please sign on the 'Participant Signature' line below.)

My signature acknowledges that I have read, understand and agree to all pages of this form and affirms that all information that I have provided is true and correct. I also understand that:

- Until cancelled, superseded or I cease to be an eligible employee, all election(s) shall apply to all eligible compensation allowed by the Plan paid from the effective date specified unless a different effective date is required under the terms of the Plan and cancels all previous elections.
- If I am increasing or decreasing my payroll deductions, all existing future deferrals will be cancelled.
- If I am stopping payroll deductions, all existing deferrals will be cancelled.
- I may change the amount of compensation contributed as allowed under the terms of the Plan.
- It is my responsibility to comply with any Internal Revenue Code deferral limits and that I may be responsible for any costs, including taxes and penalties that I may incur as a result of excess contributions.
- My Plan Administrator may take any action that may be necessary to ensure that my participation is in compliance with any applicable requirement of the Plan Document and the Internal Revenue Code.
- I authorize the payroll deduction as indicated on this form.

Any person who presents false or fraudulent information is subject to criminal and civil penalties.

**Participant Signature** \_\_\_\_\_

**Date (Required)** \_\_\_\_\_

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Social Security Number \_\_\_\_\_ 370172-01  
Number \_\_\_\_\_

<b>C</b>	<b>Signatures and Consent</b> <i>(Signatures must be on the lines provided.)</i>																			
	<b>Authorized Plan Administrator Signature</b> <i>(Please sign on the 'Authorized Plan Administrator Signature' line below.)</i>																			
	I authorize the election indicated by the participant above.																			
	<b>Authorized Plan Administrator Signature</b> _____ <b>Date (Required)</b> _____ <i>A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.</i> <b>Print Full Name</b> _____																			
<b>D</b>	<b>Mailing Instructions</b>																			
	<p>After all signatures have been obtained, this form can be</p> <table border="0"><tr><td><b>Uploaded Electronically:</b></td><td><b>OR</b></td><td><b>Sent Regular Mail to:</b></td><td><b>OR</b></td><td><b>Sent Express Mail to:</b></td></tr><tr><td>Login to account at</td><td></td><td>Empower Retirement</td><td></td><td>Empower Retirement</td></tr><tr><td><b>empowermyretirement.com</b></td><td></td><td>PO Box 173764</td><td></td><td>8515 E. Orchard Road</td></tr><tr><td>Click on Upload Documents to submit</td><td></td><td>Denver, CO 80217-3764</td><td></td><td>Greenwood Village, CO 80111</td></tr></table> <p>We will not accept hand delivered forms at Express Mail addresses.</p>	<b>Uploaded Electronically:</b>	<b>OR</b>	<b>Sent Regular Mail to:</b>	<b>OR</b>	<b>Sent Express Mail to:</b>	Login to account at		Empower Retirement		Empower Retirement	<b>empowermyretirement.com</b>		PO Box 173764		8515 E. Orchard Road	Click on Upload Documents to submit		Denver, CO 80217-3764	
<b>Uploaded Electronically:</b>	<b>OR</b>	<b>Sent Regular Mail to:</b>	<b>OR</b>	<b>Sent Express Mail to:</b>																
Login to account at		Empower Retirement		Empower Retirement																
<b>empowermyretirement.com</b>		PO Box 173764		8515 E. Orchard Road																
Click on Upload Documents to submit		Denver, CO 80217-3764		Greenwood Village, CO 80111																

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# Beneficiary Designation 401(k) Plan

**Askar Management Group, LLC 401(k) Plan**

**370172-01**

## For My Information

- For questions regarding this form, visit the website at [empowermyretirement.com](http://empowermyretirement.com) or contact Service Provider at 1-800-338-4015.
- Use black or blue ink when completing this form.

## A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

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Social Security Number (Must provide all 9 digits)

Last Name

First Name

M.I.

Date of Birth

(The name provided MUST match the name on file with Service Provider.)

( )

Daytime Phone Number

Email Address

( )

Division

Alternate Phone Number

☐ Married

☐ Unmarried

## B Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)

### Primary Beneficiary Designation (Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)

- If I am married, my Plan requires my spouse to be named as primary beneficiary for 100% of my account balance, or my spouse must consent to my beneficiary designation.
- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

%	Primary Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
---	--	--	--------------------------------

Street Address ( )	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

%	Primary Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
---	--	--	--------------------------------

Street Address ( )	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

%	Primary Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
---	--	--	--------------------------------

Street Address ( )	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)		
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

**B Beneficiary Designation** (Attach an additional sheet to name additional beneficiaries.)

**Contingent Beneficiary Designation** (Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)

%			/ /
% of Account Balance	Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
Street Address ( )	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		
%			/ /
% of Account Balance	Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
Street Address ( )	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		
%			/ /
% of Account Balance	Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
Street Address ( )	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

**C Signatures and Consent** (Signatures must be on the lines provided.)

**Participant Consent for Beneficiary Designation** (Please sign on the 'Participant Signature' line below.)

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. I acknowledge and agree that it is my responsibility to monitor the beneficiary designations in my account and to update the beneficiary designations as I deem necessary upon a change in marital status, death of a beneficiary or any other change that may impact my beneficiary designations.

If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Plan Administrator. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100%. The percentages can be divided up to two decimal points (Example: 33.33%).**

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: <http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>.

Important Notice: In accordance with ERISA and/or Plan Document, if I am married and I elect a primary beneficiary other than my spouse or in addition to my spouse, my spouse must consent by signing the Spousal Consent for Beneficiary Designation section of this form.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

**Participant Signature** \_\_\_\_\_ **Date (Required)** \_\_\_\_\_

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.



Last Name

First Name

M.I.

Social Security Number

370172-01  
Number**C Signatures and Consent** *(Signatures must be on the lines provided.)***Spousal Consent for Beneficiary Designation** *(If applicable, please have the Spouse sign on the 'Spouse's Signature' line below.)*

**Spouse to complete:** I, *(name of spouse)* \_\_\_\_\_, the current spouse of the participant, hereby voluntarily consent to the participant's primary beneficiary designation above and understand its effect. I understand that my spouse's beneficiary designation means that I will not receive 100% of his or her vested account balance under the Plan and that my spouse's election is not valid unless I consent to it. I understand that my consent is irrevocable unless my spouse changes the beneficiary designation, or designates me to receive 100% of his or her vested account balance.

**Spouse's Signature** \_\_\_\_\_ **Date (Required)** \_\_\_\_\_

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

*The spouse's signature must be notarized by a Notary Public. The date of the spouse's signature on this form in the 'My Spouse's Consent' section must match the date of the Notary Public signature in this section below.*

**Notary to complete:**

**For Residents of all states (except California),** please complete the section below.

**Notice to California Notaries using the California Affidavit and Jurat Form** the following items must be completed by Notary on the state notary form: the title of the form, the plan name, the plan number, the document date, the participant's name and spouse's name. Notary forms not containing this information will be rejected and it will delay this request.

**Statement of Notary**

**NOTE: Notary seal must be visible.**

The consent to this request was subscribed and sworn *(or affirmed)*

State of \_\_\_\_\_) to before me on this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_, by

)ss. *(name of spouse)* \_\_\_\_\_

**SEAL**

County of \_\_\_\_\_) proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.

Notary Public \_\_\_\_\_ My commission expires \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

**Authorized Plan Administrator Signature** *(Please sign on the 'Authorized Plan Administrator Signature' line below.)*

I accept the information provided by the participant on this form.

**Authorized Plan Administrator Signature** \_\_\_\_\_ **Date (Required)** \_\_\_\_\_

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

**Print Full Name** \_\_\_\_\_

**D Delivery Instructions**

**Participant forward this form to Employer**

**Employer DO NOT send this form to Service Provider. Please retain for your records.**

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