403(b) Enrollment Form

STEP 1 Participant Information

First Name | Last Name | M.I.

Address (Street Address only. P.O. Boxes not accepted) | Apartment/Suite

City | State | Zip

Daytime Phone Number | Evening Phone Number | Email Address

Social Security Number | ☐ Single ☐ Married Marital Status | Date of Birth | Date of Hire

STEP 2 Employer Information

Employer Name | Plan ID Number

Employer Address | Suite/Bldg.

City | State | Zip

Contact Name | Title | Phone Number

STEP 3 Elective Deferral Agreement

If you are eligible, according to the requirements of your employer's 403(b) plan, to enroll as a contributing participant, you may set aside a percentage or fixed amount of your pay into the plan ("elective deferrals") by signing this Elective Deferral Agreement. This Elective Deferral Agreement replaces any earlier agreement and will remain in effect as long as you remain an eligible employee or until you provide your employer with a new Elective Deferral Agreement as permitted by the Plan.

Reduce the compensation I receive each regular pay period by the following amount and contribute that amount to my 403(b) Plan account:

$ _____ OR _____ % Start Date: ☐☐–☐☐–☐☐☐☐

Note: If you are eligible to defer, your Plan permits Catch-Up Contributions and you attain (or are deemed to have attained) age 50 before the close of the Plan Year, you may make Catch-Up Contributions under the Plan. In addition, certain limits as required by law must be met prior to being eligible to make Catch-Up Contributions. See your Plan Administrator for the Catch-Up Contribution limit for the year, and additional information.

I will have attained age 50 (or older) prior to the end of the plan year and wish to make an additional "catch-up" contribution in the amount of:

$ _____

I agree that my pay will be reduced in the manner I have indicated above and that these dollars will be deferred into the 403(b) Plan. This Elective Deferral Agreement will continue to be in effect while I am employed, unless I change or terminate it. I acknowledge that I have read this entire agreement, understand it and agree to its terms. In addition, in the event that an erroneous contribution or excess contribution is made to my account, I authorize my employer to make necessary corrections to ensure elective deferrals made to my account are in accord with the limits specified in the following sections of the Internal Revenue Code: the elective deferral limitations in Sections 402(g) and 414(v) and the annual additions limitations in Section 415(c). I have received the 403(b)(7) Custodial Account Agreement and I adopt the terms of the 403(b)(7) Plan and appoint MG Trust Company as custodian. I authorize MG Trust Company or its agent to perform those functions an appropriate administration services as specified. I understand the following fees will be collected by redeeming sufficient shares from my account balance: (1) an annual $40 maintenance fee (2) a 0.10% custody/ adminstration fee of the value of my account.

▶ _____ ☐☐–☐☐–☐☐☐☐

Date (month | day | year)

STEP 4 Beneficiary Designation

I designate the following person(s) or entity(ies) below as my beneficiary(ies) to receive payment of the value of my 403(b) plan upon my death.

☐ Primary
☐ Contingent

Beneficiary's Name (first, middle, last) or Entity Name

Address, City, State, Zip

Daytime Phone Number | Evening Phone Number | Email Address

Social Security Number | Date of Birth (if applicable) | Percentage Share | Relationship to Participant

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☐ Primary
☐ Contingent

Beneficiary's Name (first, middle, last) or Entity Name

Address, City, State, Zip

Daytime Phone Number | Evening Phone Number | Email Address

Social Security Number | Date of Birth (if applicable) | Percentage Share | Relationship to Participant

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☐ Primary
☐ Contingent

Beneficiary's Name (first, middle, last) or Entity Name

Address, City, State, Zip

Daytime Phone Number | Evening Phone Number | Email Address

Social Security Number | Date of Birth (if applicable) | Percentage Share | Relationship to Participant

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I understand that if no beneficiary survives me or if my beneficiary(ies) cannot be located, the plan will distribute the benefits to my estate. I understand that if I fail to indicate share percentages, all benefits will be divided equally among the beneficiaries I designate.

▶ ____________________ Date (month | day | year)

Note: Spousal consent is required if the participant is married and the designated primary beneficiary is not the participant's spouse. The spouse's signature must be witnessed by either (1) a authorized representative of the Plan or (2) a Notary Public.

Spousal Waiver: I hereby consent to the above beneficiary designation.

▶ ____________________ Date (month | day | year)

Signed before me ________ day of ________________, 20______.

▶ ____________________ Date (month | day | year)

County of ____________________ State of ____________________ Commission expiration date ___________.

PLAN ADMIN USE ONLY: Approved for participation as of ____________________ by ____________________ Date ____________

Appointment of Authorized Agent

Use this form to appoint a financial professional to your account

STEP 1 Participant Authorization

Powers You Give Your Authorized Agent

Account Access & Limited Trading Authority
Limited Trading Authority allows your Authorized Agent to inquire in your account(s), direct investments from the available options within the Plan. The Authorized Agent is bound by all terms and conditions set forth in all customer agreements related to your accounts. Limited Trading Authorization does not allow your Agent to transfer, withdraw, or disburse money or assets from your account except as may be pursuant to an authorization to deduct management fees. Neither 403(b) ASP , its agents, nor 401(k) ASP, Inc. assumes any responsibility for reviewing or monitoring any investment decision or activity of the Authorized Agent.

Authorization to Pay Management Fees to Authorized Agent
I authorize you to pay Agent from my assets held in the 403(b) FundSource account registered in my name, the management fees specified in my Investment Advisory Agreement with Agent as invoiced by Agent. You shall rely on Agent's invoices and have no responsibility for the calculation or verification of the fees. This Authorization will remain in full force and effect until 403b ASP shall have received from me written notice of its revocation signed by me. The authorization shall extend to the benefit of your successors and assigns.

Signature of Owners
I, the Account Owner(s) have read this form in its entirety, agree to be bound by this document as it exists and as it may be modified, and designate the Authorized Agent listed in Section 2 to act as my agent and attorney-in-fact to exercise all rights and powers set forth herein with respect to the Account(s) listed below. I authorize 403(b) ASP, its affiliates, agents and any other person 403(b) ASP may instruct to act in connection with my Authorized Agent's instructions to rely on my Authorized Agent's instructions without further approval or direction from me. This authorization will terminate if 403(b) ASP is notified in writing of my incapacity, disability or death. I may revoke this authorization by notifying 403(b) ASP in writing, but such notification will not affect my responsibility for any actions of my Authorized Agent prior to 403(b) ASP receipt and processing of the notification.

▶ _____ Date (month | day | year) __ __ – __ __ – __ __ __ __

Print Full Name _____ Social Security Number __ __ __ – __ __ – __ __ __ __

Employer Name _____ Plan ID Number _____

STEP 2 Authorized Agent Information (This section to be completed by Authorized Agent)

I certify that I am/we are a (select only one)

☐ Registered Representative

Compensation method by 12(b)1 commissions paid by the mutual fund companies in which the participant is invested.

☐ Registered Investment Advisor

Compensation method by advisory fee of _____ %

If the Registered Owner(s) has/have authorized paying management fees above, I will provide you true and accurate information of the management fees owed to me by the Registered Owner(s) which you are to deduct from the account and pay to me. I will send the Registered Owner(s) notification of the amount of each invoice that I provide to you. I will indemnify and hold you, your agents and your directors, officers and employees harmless from all liabilities and costs, including attorney fees, which you may incur by relying upon my representation or upon the above Authorization. This indemnification shall extend to the benefit of your successors and assigns.

▶ _____ Date (month | day | year) __ __ – __ __ – __ __ __ __

Contact Name _____ Phone Number _____ Rep ID (if applicable) _____

Firm Name _____ Branch ID Number _____

Firm Address _____ Suite/Bldg. _____

City _____ State _____ Zip _____

Investment Election Form

Use this form to make your investment elections for your account

Consult with your Financial Advisor regarding the available mutual fund investment choices for your 403b FundSource account. For questions regarding the investment choices visit your Plan's dedicated 403(b) website or call the participant help desk at 866-401-5277.

STEP 1 Your Investments Choices

Ticker Symbol	Investment Name	Allocation %

PLEASE NOTE: Your total must equal 100% **TOTAL**

STEP 2 Investment Authorization

Before investing, consider the investment objectives, risks, charges and expenses. Contact your advisor or 403b FundSource for a prospectus containing this information. Read it carefully.

I acknowledge that I have received and read the prospectus for the investment(s) selected and this account will be subject to the prospectus as amended from time to time. I will obtain the current prospectus for each fund into which I may exchange before I request the exchange. Furthermore, I understand that if I fail to complete the investment election correctly, I will be deemed to direct that future contributions will be invested in the plans default fund.

▶ Date (month | day | year)

Print Full Name — Social Security Number

Employer Name — Plan ID Number