

New plan enrollment

 Request changes to existing account

# 1 Employee information

First name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Residence address (physical address of owner — no P.O. boxes) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

-   -

SSN or ITIN \_\_\_\_\_  
 Date of birth (mm/dd/yyyy) \_\_\_\_\_ Date of hire (mm/dd/yyyy) \_\_\_\_\_ Country of citizenship \_\_\_\_\_

Married     Unmarried

# 2 Employee contributions

I authorize my employer to withhold from my wages each pay period an amount equal to:  
 Before-tax contributions: \_\_\_\_\_% **OR** \$\_\_\_\_\_

I do **not** wish to participate in the salary deferral portion of the plan at this time.

# 3 Investment options and allocations

Please invest my contributions as follows: (Only **whole** percentages will be accepted.)

	Fund name	Percentage
1.	_____	_____%
2.	_____	_____%
3.	_____	_____%
4.	_____	_____%
5.	_____	_____%
6.	_____	_____%
7.	_____	_____%
8.	_____	_____%
9.	_____	_____%
10.	_____	_____%
11.	_____	_____%
12.	_____	_____%
<b>Total</b>		<b><u>100%</u></b>

**Any contributions to participant accounts (conversion assets, payroll deferrals or rollovers) made prior to American Funds receipt of this form will be invested in the plan's default fund. Assets will remain in the default fund until you use the participant website to exchange assets into the funds of your choice.**

# 4 Employee signature

By signing below, I acknowledge I have authorized my employer to withhold the specified amount listed above from my wages. I acknowledge that I have completed a Beneficiary Designation form.

**X** \_\_\_\_\_ Date     /     /      
 Signature of Participant (mm/dd/yyyy)

**PLEASE RETURN THIS FORM TO YOUR EMPLOYER TO COMPLETE THE SECTION BELOW.**

**5 Employer authorization**

*This section to be completed and the form retained by employer.*

\_\_\_\_\_  
Name of employer, organization or company

\_\_\_\_\_  
Name of plan

\_\_\_\_\_  
Plan ID #

The employee listed in Section 1 of this document is eligible for the plan, and deferrals can begin as of \_\_\_\_/\_\_\_\_/\_\_\_\_.  
(mm/dd/yyyy)

**Authorization**

\_\_\_\_\_  
Name of signer for employer (please print)

**X**  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

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