401(K) SAVINGS APPLICATION

PESG, LLC 401(k) Profit Sharing Plan
342020-01
Retirement Plan Enrollment

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 ____-____

Mailing address (if different from residence address) ________ City ________ State ____ ZIP ____-____

Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐ Date of hire (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐ Country of citizenship ________

Marital status: ☐ Married ☐ Single **Gender:** ☐ Male ☐ Female

2 Employee contributions

Before completing this section, please check with your plan to determine the contribution options you have available.

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

☐ I do **not** wish to make contributions at this time.

☐ 3% Default Enrollment

Please Note: If no selection is made at open enrollment, you will become a 401(k) participant with a 3% salary deferral per the plan's automatic enrollment guidelines.

3 Investment Selection

Please invest my contributions as follows: (Only whole percentages will be accepted; must total 100%.)

	Fund name	Percentage
1.	AMCAP Fund	____%
2.	Davis New York Venture Fund R	____%
3.	EuroPacific Growth Fund	____%
4.	Oppenheimer Global Fund N	____%
5.	SMALLCAP World Fund	____%
6.	The Growth Fund of America	____%
7.	Capital World Growth and Income Fund	____%
8.	The Investment Company of America	____%
9.	Capital Income Builder	____%
10.	American Balanced Fund	____%
11.	The Bond Fund of America	____%
12.	The Cash Management Trust of America	____%
13.	American Fund Target Date 2050	____%
14.	American Fund Target Date 2045	____%
15.	American Fund Target Date 2040	____%
16.	American Fund Target Date 2035	____%
17.	American Fund Target Date 2030	____%
18.	American Fund Target Date 2025	____%
19.	American Fund Target Date 2020	____%
20.	American Fund Target Date 2015	____%
21.	American Fund Target Date 2010	____%
	Total	**100%**

Any contributions to participant accounts (conversion assets, payroll deferrals and rollovers) made before your employer updates your investment selections for your account 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 that I have authorized my employer to withhold the amount specified in Section 2 from my wages. I acknowledge that I have completed a beneficiary designation form.

X ______________________________ ___/___/______
Participant's signature Date (mm/dd/yyyy)

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

5 Employer authorization

Employer: please complete this section and retain this form for your records.

PESG, LLC
Name of employer, organization or company

PESG, LLC 401(k) Profit Sharing Plan **342020-01**
Name of plan Plan ID #

The employee named in Section 1 of this document is eligible to participate in the plan as of ___/___/______ (mm/dd/yyyy).

______________________________ ______________________________
Name of signer for employer *(print)* Title

X ______________________________ ___/___/______
Authorized signature Date (mm/dd/yyyy)

Beneficiary Designation

Please read the following carefully before completing the "Beneficiary designation" section below.

The designation of a beneficiary can have important tax consequences. You are encouraged to consult with your tax adviser before completing this form. Neither American Funds Distributors, Inc. (AFD), Capital Bank and Trust Company (CB&T) nor any affiliate of CB&T shall be liable for any claim, loss, damage or expense arising out of or in any manner connected with a distribution pursuant to this completed Beneficiary Designation form. You should periodically review and update your beneficiary designations as appropriate.

If you are not married at the time you designate your beneficiaries and subsequently marry, 100% of your account balance will be paid at the time of your death to the surviving spouse unless your spouse signs Section 3 of this form.

1 Information about you

Please type or print clearly.

PESG, LLC
Name of employer

☐☐☐-☐☐-☐☐☐☐
SSN of participant

Name of participant

☐☐-☐☐-☐☐☐☐
Date of birth (mm/dd/yyyy)

2 Beneficiary designation

If the percentages don't add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. If you wish to customize your designation or need more space, please attach a separate sheet.

I revoke all previous designations and direct that this account be distributed upon my death to the designated beneficiary(ies) below.

If a designated primary beneficiary dies prior to the owner, that primary beneficiary's share will be divided equally among the surviving primary beneficiaries. If no primary beneficiary(ies) survives the participant, benefits will be paid to the contingent beneficiary(ies).

Primary beneficiary(ies): (If you're married and naming someone other than your spouse as the primary beneficiary, Section 3 of this document must be completed.)

First name (print) ____ MI ____ Last ____ Relationship ____ ____ %

☐☐☐-☐☐-☐☐☐☐ SSN ☐☐-☐☐-☐☐☐☐ Date of birth (mm/dd/yyyy)

First name (print) ____ MI ____ Last ____ Relationship ____ ____ %

☐☐☐-☐☐-☐☐☐☐ SSN ☐☐-☐☐-☐☐☐☐ Date of birth (mm/dd/yyyy)

100%

Contingent beneficiary(ies): (Complete only if you're naming a primary beneficiary above.)

First name (print) ____ MI ____ Last ____ Relationship ____ ____ %

☐☐☐-☐☐-☐☐☐☐ SSN ☐☐-☐☐-☐☐☐☐ Date of birth (mm/dd/yyyy)

First name (print) ____ MI ____ Last ____ Relationship ____ ____ %

☐☐☐-☐☐-☐☐☐☐ SSN ☐☐-☐☐-☐☐☐☐ Date of birth (mm/dd/yyyy)

100%

Signature:

X ____
Participant's signature

___ / ___ / ___
Date (mm/dd/yyyy)

3 Spousal consent

By signing this spousal consent, I verify that I am the spouse of the participant whose name appears on this form. I understand that my spouse has chosen to name someone other than me as the sole primary beneficiary under this plan and that this designation is not valid without my irrevocable consent. I hereby irrevocably consent to the beneficiary designation on this form. I further acknowledge that my consent is irrevocable unless my spouse revokes this designation.

First name (print) ______ MI ______ Last ______

X ______ Signature ______ Date (mm/dd/yyyy) ___/___/___

Either a plan representative appointed by the employer or a notary public must witness the signature of the spouse.

Georgette Bledsoe
Name of plan representative (print)

X ______ Plan representative's signature

X ______ Notary public's signature ______ State ______ County

Subscribed and sworn to me the ______ day of ______ (Month), 20 ______

Office of Retirement Services
P.O. Box 30171
Lansing MI 48909-7671
(800) 381-5111 (Lansing area 322-5103)
www.michigan.gov/ors

Public School Employees Refund Application

OFFICE USE ONLY

Applicant Instructions: **You must complete Sections A and D.** If you choose option 2 or 3 in Section A, have your financial institution complete Section B. If you terminated public school employment within the last two years, have your last employer complete Section C. Mail your completed application to ORS at the above address, or you can fax it. Contact ORS for a current fax number. You will normally receive your refund within 90 days from the date the Retirement System receives your properly completed application. If your application is incomplete, it will be returned to you for correction.

Section A: To be completed by refund applicant. (Please Print)

NAME		SOCIAL SECURITY NUMBER
ADDRESS		DATE OF BIRTH
CITY, STATE, ZIP		DAYTIME TELEPHONE NUMBER
LAST NAME(S) USED WHILE EMPLOYED	REPORTING UNIT (SCHOOL DISTRICT) NAME	DATE LAST WORKED IN ANY MICHIGAN PUBLIC SCHOOL

Refund Election: *The Michigan Public School Employees Retirement System is a qualified pension plan under Section 401 (a) of the Internal Revenue Code and must comply with federal regulations regarding payment of refunds. Therefore, please select one of the following three options:*

☐ **1.** I wish to have my refund paid directly to me. I understand that 20% of the sum of my previously untaxed contributions and accrued interest will be withheld as federal income tax withholding.

☒ **2.** I wish to have my previously untaxed contributions and interest transferred directly into the qualified retirement plan or individual retirement arrangement indicated in Section B. I understand any previously taxed contributions will be refunded to me.

☐ **3.** I wish to have $__________ of my previously untaxed contributions and interest transferred directly into the qualified retirement plan or individual retirement arrangement indicated in Section B. Please pay the remainder of my refund directly to me. I understand that 20% of the previously untaxed contributions and interest paid to me will be withheld as federal income tax withholding.

Section B: To be completed by financial institution, ONLY IF Option 2 or 3 in Section A is selected.
After completing Section B, return form to refund applicant.

In accordance with the authorization in Section A, we agree to deposit the forthcoming rollover amount from the Michigan Public School Employees Retirement System into the following account. We understand the rollover may take up to 90 days to process.
Please check the type of account: ☐ Individual Retirement Account (IRA) ☒ Qualified Pension Plan

MAKE CHECK PAYABLE TO: (PLAN OR IRA NAME)		ACCOUNT NUMBER
PESG, LLC 401(k) Profit Sharing Plan		**342020-01**
ADDRESS **Capital Bank & Trust; 3550 Rockmont Dr. Mail Stop DN-CL-OCLB; Lockbox 0985**	CITY, STATE, ZIP **Denver, CO 80202**	
SIGNATURE OF PLAN ADMINISTRATOR OR TRUSTEE	TELEPHONE NUMBER **(616) 891-0509**	DATE

Section C: To be completed by a payroll official of the applicant's last public school employer ***if employment ended within the last two years.*** *After completing Section C, return form to refund applicant.*

I certify that ______________________ (EMPLOYEE NAME) ______________________ (SOCIAL SECURITY NUMBER*) has:

☐ ceased all employment in this reporting unit, is not on leave of absence, and is not on layoff expected to last less than 12 months; or

☐ has elected to participate in an Optional Retirement Plan (ORP).

REPORTING UNIT NAME	REPORTING UNIT NUMBER	LAST DATE CONTRIBUTIONS WITHHELD FROM EMPLOYEE WAGES

REPORTING UNIT OFFICIAL SIGNATURE	DATE SIGNED

REPORTING UNIT OFFICIAL TITLE	TELEPHONE NUMBER

Section D: To be completed by refund applicant. ***Your signature must be witnessed by a Notary Public before the Retirement System will process this application.***

I certify I have read the provisions regarding payment of refunds from this Retirement System and, after careful consideration, have decided that, **even if eligible for future benefits,** I still request a refund. I realize I am giving up my retirement rights accumulated under the contributory plan by taking a refund.

I certify I have ceased employment in all public-supported educational institutions under this Retirement System, am not on leave of absence and am not on a layoff expected to last 12 months or less, or have elected to participate in an optional retirement plan. I request that the accumulated balance in my account plus interest be refunded as indicated in Section A. I understand that by accepting the refund and/or transfer, I am releasing the Michigan Public School Employees Retirement System from any claim of accumulated benefits under the contributory plan and hereby forfeit such rights and benefits.

SIGNATURE OF REFUND APPLICANT	DATE

Notary Public:

Subscribed and sworn to before me this ________ day of ____________________, A.D. __________

County of ________________, State of ________________.

My Commission Expires ________________, __________.

STAMP

____
NOTARY SIGNATURE