TRANSAMERICA®
Retirement Solutions

Automatic Enrollment Opt Out and Refund Form

INSTRUCTIONS AND INFORMATION FOR COMPLETING THIS FORM

Use this form if you were automatically enrolled in the plan and are opting out of the Automatic Enrollment Program. IRS rules state that this request must be made within 90 days of the first automatic deferral. The IRS rules also state that the effective date of the Opt Out election cannot be after the earlier of:

1. **The pay date of the second payroll period beginning after the election is made, or**
2. **The first pay date that occurs at least 30 days after the election is made.**

Participants must go on-line and log into Transamerica.com to change their contribution rate to 0% or contact the company's Payroll Department to change their contribution rate to 0%.

This form must be completed and signed by you and the plan administrator, trustee or an authorized plan signer. If any information is missing or incomplete, you may be required to complete a new form or provide additional information before the distribution can be processed.

Some Facts On Opt Out Refunds:

- Employee contributions, adjusted for any gains or losses through the distribution date, will be refunded to the participant
- Any employer matching contributions, adjusted for any gains or losses through the distribution date, will be forfeited and applied based on your plan's provisions.
- Participant will receive a Form 1099-R for the year in which the refund is distributed.
- A refund of automatic contributions can **not** be rolled over to another qualified plan
- The refund amount will be taxable to the participant in the year of distribution. An early withdrawal penalty will not apply.

PARTICIPANT INSTRUCTIONS

1. Complete Sections B-D
2. Your signature is required in Section D
3. Submit this form to your Employer for signature and processing. **Do not mail this form directly to the Administration Office listed at the end of this form.**

EMPLOYER INSTRUCTIONS

1. Complete Section A.
2. Your signature is required in Section D.
3. Submit this form to the Processing Center.

SECTION A. EMPLOYER INFORMATION

Company/Employer Name

FRIENDS of SWITCHPOINT

Plan Name | Contract Number | Division Number/Sub-id *(if applicable)*

SECTION B. PARTICIPANT INFORMATION — *PLEASE PRINT*

Social Security No. – – | Date of Birth (mmddyyyy) – – | Date of Hire (mmddyyyy) – – | E-mail Address

Last Name | First Name/Middle Initial

Street Address/Apt. No. | Phone No. ( ) – | Ext. (if any)

City | State | Zip Code

MAIL DELIVERY OF DISTRIBUTION

All checks will be sent via First Class Mail.

SECTION C. ELECTION

I am requesting to opt out of the Automatic Enrollment Program and have the contributions deducted refunded to me. Please have the check made payable to me.

SECTION D. REQUIRED SIGNATURES

My signature acknowledges that I have read, understand and agree to all the terms of this form, and affirm that all information that I have provided is true and correct. I understand that opting out at this time does not prohibit me from rejoining and participating in the plan at any time in the future, subject to plan provisions.

Signature of Participant | **Opt Out Election Date**

MUST BE COMPLETED BY THE PLAN ADMINISTRATOR, TRUSTEE OR AUTHORIZED PLAN SIGNER ONLY

By signing below, I hereby authorize Transamerica to process the request as elected in Section C of this form. This request is in compliance with plan provisions and I have verified that the participant has requested to opt out of the Automatic Enrollment Program and receive a refund within the time period prescribed by the IRS. I have verified that the participant has changed their contribution rate to 0%.

By: Signature of Plan Administrator, Trustee or Authorized Plan Signer | **Date**

Print Name of Plan Administrator, Trustee or Authorized Plan Signer | **Date**

Once this form has been completed with all of the necessary information and required signatures, please forward to the Processing Center for processing. This form cannot be processed without the plan administrator, trustee or authorized plan signer's signature.

Be sure to keep a photocopy for your records.

MAIL TO: Processing Center: 6400 C Street SW, Cedar Rapids, IA 52499 **Fax #:** 866-846-2236