TRANSAMERICA®

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-E.
2. Your signature is required in Section E.
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 E.
3. Submit this form to the Processing Center.

SECTION A. EMPLOYER INFORMATION

_____

Company/Employer Name

_____

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

SECTION B. Participant Information – *Please print*

_____-_____-_____ _____-_____-_____ _____-_____-_____

Social Security Number Date of Birth (MM-DD-YYYY) Date of Hire (MM-DD-YYYY)

_____ _____ _____

Last Name First Name MI

_____ _____

Street Address/Apt. No. City State Zip Code

(_____) _____ _____

Phone Number Email Address

MAIL DELIVERY

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. TAX WITHHOLDING ELECTION

Withholding elections determine the amount of your distribution that will be withheld and paid to the respective tax authorities, in anticipation of income taxes due on the taxable portion of your distribution. This withholding in no way represents your final liability due on these amounts and you should consult with your tax advisor regarding appropriate reporting on your annual income tax returns. You remain liable for the full amount of any taxes due, including any early withdrawal penalties. Therefore, you may need to pay additional taxes and could incur penalties if withholding or estimated tax payments for the year are not enough to cover your liability.

Federal Income Tax Withholding
Your distribution will be subject to a 10% withholding unless you select a different percentage between 0% and 100% on IRS Form W-4R. The IRS Form W-4R can be found at https://www.irs.gov/pub/irs-pdf/fw4r.pdf or from www.irs.gov. If the appropriate form is not included, the default withholding will apply.

State Income Tax
The state of withholding will be presumed to be the state that has been provided in your address as previously provided on the form. Tax withholding rules vary by state. More likely than not, your home state (a) requires a minimum withholding amount when federal withholding is required; (b) requires withholding unless you can opt out; (c) allows a voluntary withholding election; or (d) does not have state income tax and does not permit withholding. Unless requested, state withholding will not be deducted for states with voluntary withholding. *Some states require the completion of their State Withholding Certificate to make an independent election. Consult with your tax advisor or state revenue department to obtain the most up-to-date information and to confirm if your state's withholding form is required to be submitted.* **If permitted by your state, please select one of the options below.**

☐ NO, I ELECT NOT TO HAVE STATE INCOME TAX WITHHELD

☐ YES, I ELECT TO HAVE _____ % AS STATE INCOME TAX WITHHELD

☐ YES, I ELECT TO HAVE $_____ (WHOLE DOLLAR ONLY) AS STATE INCOME TAX WITHHELD

☐ YES, I ELECT TO HAVE STATE INCOME TAX WITHHELD USING THE DEFAULT FILING STATUS AS PER MY STATE OF RESIDENCE WITHHOLDING CERTIFICATE (Note: ONLY CHECK THIS BOX FOR PERIODIC PAYMENTS WITHHOLDING).

NOTE: Withholding may be greater if the amount you select is less than the minimum required. Withholding will be processed for states that require withholding or do not allow you to opt out without your state's form.

SECTION E. 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 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 Signer **Date**

_____ _____

Print Name of Plan Administrator, Trustee or Authorized 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