Print Form

ENROLLMENT AND CHANGE APPLICATION

dailyaccess CORPORATION

PLAN PARTICIPANT INFORMATION

Employer/Plan Name: Summit Healthcare

Participant Name: _____

Social Security #: _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Do **not** use this form for investment elections. All investment elections and investment election changes must be made through either the automated telephone information system or the Participant Website. Please see your plan sponsor for details and information on changing investment elections.

TYPE OF ENROLLMENT

☐ New ☐ Re-entry ☐ Change Effective Date: _____

SELECTION INFORMATION

- ☐ I choose to make salary deferral contributions to the plan.
- ☐ I choose not to make salary deferral contributions to the plan.
- ☐ I want to change my current contribution amount.
- ☐ I want to stop my payroll contributions.

Note: If you only want to change your beneficiary, you do not need to fill out this form. Instead, please complete and return a new Designation of Beneficiary Form to your employer.

DUTY TO REVIEW PAY RECORDS

I understand I have a duty to review my pay records (pay stub, etc.) to confirm the Employer properly has implemented my salary reduction election. Furthermore, I have a duty to inform the Plan Administrator if I discover any discrepancy between my pay records and this Salary Reduction Agreement. I understand the Plan Administrator will treat my failure to report any withholding errors for any payroll to which my Salary Reduction Agreement applies, by the cut-off date for the next following payroll, as my affirmative election to defer the amount actually withheld (including zero). However, I thereafter may modify my deferral election prospectively, consistent with the Plan terms.

SALARY DEFERRAL INFORMATION

1. I authorize Summit Healthcare (employer name) to withhold from my cash wages each pay period an amount equal to $ X dollars or _____ %.
2. My employer shall pay to the plan all such amounts withheld for crediting to my account.
3. I have the right to change, amend or otherwise revoke this agreement subject to plan provisions.

AUTHORIZATION

_____ _____

Participant's Name (please sign) **Date**

_____ _____

Plan Sponsor's Name (please sign) **Date**