

PARTICIPANT CHANGE FORM

Social Security Number

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Plan Number:

30966

Plan Name: **GoTechNow 401(k) Plan**

Old Information

Participant Name:

Last First Middle Initial

Participant Address:

Street

City State Zip

New Information

(Provide ONLY the information that has **CHANGED**.)

Social Security Number: _____ -- _____ -- _____

Participant Name:

Last First Middle Initial

Participant Address:

Street

City State Zip

Division: _____ Hire Date: _____ Birth Date: _____

New Pretax Contribution Percentage or Amount

I elect to contribute each payroll period the following whole percentage of my eligible Compensation on a **PRETAX** basis: _____%.

(The percentage indicated cannot exceed 85% of your eligible Compensation unless you are age 50 or will turn age 50 during the current calendar year. For the calendar year, your total pretax contributions and any catch-up contributions and Roth 401(k) contributions for eligible participants cannot exceed the applicable dollar limit, in effect, under Federal law. Eligible Compensation under the Plan is limited to the applicable dollar limit in effect under Federal law for the Plan Year.)

New Roth 401(k) Contribution Percentage or Amount

I elect to contribute each payroll period the following whole percentage of my eligible Compensation as a **Roth 401(k) contribution**: _____%.

Effective date of Roth 401(k) contribution change: _____

(Your total Roth 401(k) and pre-tax contributions cannot exceed 85% of your eligible Compensation unless you are age 50 or will turn age 50 during the current calendar year. For the calendar year, your total Roth 401(k) and pretax contributions and any catch-up contributions for eligible participants cannot exceed the applicable dollar limit in effect under Federal law. Eligible Compensation under the Plan is limited to the applicable dollar limit, in effect, under Federal law for the Plan Year.)

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Participant Signature

I hereby certify that the above Participant information is true, accurate and complete. If the New Contribution Percentage section is completed then I authorize my employer to reduce my eligible Compensation by the indicated percentage and to make a contribution to the Plan on my behalf. I understand that my contribution election will become effective on the first payroll period that my Employer can reasonably process it and that my election will continue in the effect until I revoke it or terminate my employment.

PARTICIPANT _____ **DATE** _____

Plan Administrator Use Only

Participation Date: _____ **Vesting Date:** _____

Years of Service: _____ **Rehire Date:** _____

Employee No.: _____ **Division:** _____

Plan Administrator Signature

As Plan Administrator I authorize the Participant's changes on this form.

PLAN ADMINISTRATOR SIGNATURE* _____ **DATE** _____

PLAN ADMINISTRATOR PRINT NAME* _____

*Note: The Plan Administrator should both print and sign their name in the spaces given.

Form Completion Checklist

Before submitting this form, please verify that you have included the following information:

- Participant's social security number
- Participant signature
- Plan Administrator signature