Spectrum ERISA Settlement
P.O. Box 2010
Chanhassen, MN 55317-2010
www.SpectrumERISASettlement.com

FORMER PARTICIPANT CLAIM FORM

If you were a participant in a defined contribution retirement plan known as the Spectrum Health System 403(b) Plan (the "Plan") on or after September 14, 2014 through March 13, 2023 (the "Class Period"), but you do not have an Active Account with the Plan, or are a Beneficiary or Alternate Payee (in the case of a person subject to a Qualified Domestic Relations Order) of a Former Participant, and would like to receive a payment from the *McNeilly, et al. v. Spectrum Health System et al.* Settlement, you must complete the form below and mail it to:

Spectrum ERISA Settlement Administrator
P.O. Box 2010
Chanhassen, MN 55317-2010

to be received NO LATER THAN JULY 11, 2023.

"Active Account" means an individual investment account in the Plan with a balance greater than $0. "Former Participant" means a person who had an Active Account with a positive balance in the Plan during the Class Period but who did not have an account with the Plan with a balance greater than $0 as of March 13, 2023. "Beneficiary" or "Alternate Payee" means, for the purposes of this Former Participant Claim Form, a Beneficiary or Alternate Payee of a participant in the Plan who maintained a positive account balance in the Plan during the Class Period, but did not have an active account in the Plan as of March 13, 2023.

PARTICIPANT INFORMATION

First Name | M.I. | Last Name

Mailing Address

City | State | Zip Code

Phone (*Preferred*) — —

Phone (*Alternate*) — —

Participant's Social Security Number — —

Participant's Date of Birth — —
M M D D Y Y Y Y

Email Address

[FORMER PARTICIPANT CLAIM FORM CONTINUES ON THE NEXT PAGE]

BENEFICIARY OR ALTERNATE PAYEE INFORMATION

(ONLY PROVIDE IF THIS PERSON SHOULD RECEIVE PAYMENT INSTEAD OF THE PARTICIPANT)

Your First Name | M.I. | Last Name

Your Mailing Address

City | State | Zip Code

Your Phone (*Preferred*)

Phone (*Alternate*)

Your Social Security Number

Your Date of Birth

M M D D Y Y Y Y

Your Email Address

PAYMENT ELECTION (*CHOOSE ONLY ONE*)

☐ **I WANT A CHECK MADE PAYABLE TO ME AND MAILED TO ME.** Choosing this option entails the Settlement Administrator withholding 20% or more of your total payment for tax withholdings. The Settlement Administrator will mail your check to the Name and Address listed above.

☐ **I WANT A CHECK MADE PAYABLE TO MY RETIREMENT ACCOUNT AS A ROLLOVER DISTRIBUTION. PLEASE MAKE THE CHECK PAYABLE TO:**

Account Name

Account Number

Contact or Trustee (*if required*)

Mailing Address Line 1

Mailing Address Line 2

City | State | Zip Code

NOTE: There is no promise or assurance that these funds are eligible for rollover or tax-preferred treatment. The decision to seek rollover treatment is yours alone. Any questions about taxation or rollover treatment must be directed to your tax advisor or accountant. No one associated with this case can provide you with assistance or advice of any kind in this regard or answer any tax questions.

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REQUIRED CERTIFICATION REGARDING QUALIFIED DOMESTIC RELATIONS ORDER ("QDRO"):

I hereby certify and represent under penalty of perjury that no portion of the payment to be received hereunder is subject to a QDRO, or, that a true, accurate, and current copy of any applicable QDRO is attached hereto along with the name and address of any payee other than the Class Member. Payment will be made in accordance with any QDRO supplied.

M M D D Y Y Y Y

Signature ***(Required)***

Date Signed ***(Required)***

DECEASED CLASS MEMBERS

Deceased Class Members are not eligible for rollover treatment. A Beneficiary of a deceased person who was a participant in the Plan at any time during the Class Period, including executors, heirs, assigns, estates, personal representatives, or successors-in-interest, must provide the following information with this Former Participant Claim Form to

Spectrum ERISA Settlement Administrator
P.O. Box 2010
Chanhassen, MN 55317-2010:

- Evidence that such person is authorized to receive distribution of the deceased Class Member's settlement payment, and the name and, if applicable, the percentage entitlement of each person entitled to receive distribution;
- Social Security Number of each person entitled to receive payment;
- Current mailing address of each person entitled to receive payment; and
- Person(s) to whom check(s) should be made payable, and amount(s) of check(s).