Cypress Pointe Surgical Hospital 401(k) Plan
Enrollment & Investment Election

Employee Data

Employee Name	Social Security Number	
Address	City, State, Zip	
Date of Birth	Employment Date	Employee Number
Marital Status	Spouse's Name	Spouse's Date of Birth

I understand I am eligible to participate in the Plan and acknowledge that I have received a Summary of the Plan Provisions. A copy of the Plan document is on file in the Company's business office and is available to me during normal business hours for review and copying, at my expense.

Election to Participate

☐ **Initial Deferral Election** ☐ **Change to Prior Election**

I elect to Participate and defer _____% of Compensation or $_____ per pay period.

☐ **Election Not to Participate in the Salary Deferral option of the Plan**
I hereby elect not to participate in the Salary Deferral option of the Plan. I understand the Plan provisions governing my future eligibility under the plan.

Investment Fund Selections

		Future Contributions % to be invested into each fund	Prior Balance % to be invested into each fund ☐ Same as Future Contributions
Stable Value	Invesco Liquid Assets Portfolio - Private	%	%
Income	PIMCO Total Return (PTRRX)	%	%
Income	Templeton Global Bond (FGBRX)	%	%
Growth & Income	Calamos Growth & Income (CGNRX)	%	%
Growth & Income	MFS Value (MEIGX)	%	%
Growth	Fidelity Advisor New Insights (FNITX)	%	%
Growth	Goldman Sachs Mid Cap Value (GCMRX)	%	%
Growth	American Century Heritage (ATHWX)	%	%
Aggressive	American Century Small Cap Value (ASVRX)	%	%
Aggressive	MFS New Discovery (MNDGX)	%	%
International	First Eagle Global (SGENX)	%	%
International	Oppenheimer Developing Markets (ODVNX)	%	%

The following are Asset Allocation Funds. Investments are based on your estimated retirement date.

Asset Allocation Fund	T. Rowe Price Retirement 2015 (RRTMX)	%	%
Asset Allocation Fund	T. Rowe Price Retirement 2025 (RRTNX)	%	%
Asset Allocation Fund	T. Rowe Price Retirement 2035 (RRTPX)	%	%
Asset Allocation Fund	T. Rowe Price Retirement 2045 (RRTRX)	%	%
		100%	100%

Signatures

I understand: (1) my election regarding the type of deferrals is irrevocable once the employer withholds the deferrals from my pay; and (2) any change of election regarding the type of deferrals is effective only for deferrals from my pay after the Plan Administrator accepts my change of election.
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 that my failure to report any discrepancy may result in a loss of or reduction in my ability to defer.

Employee Signature	Date
Plan Administrator	Date

BENEFICIARY DESIGNATION FORM

Cypress Pointe Surgical Hospital 401(k) Plan

(Plan Sponsor: Keep this completed form in employee's personnel file.)

Your Info

Please type or print clearly

Last Name _____ First Name _____ M.I. _____ Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

If this beneficiary designation form is not completed, either a prior designation or the plan document will govern the distribution of any death benefit. No individual named as Beneficiary shall be entitled to receive payment unless such individual shall survive the Participant. Except as otherwise expressly provided in this designation, if no Beneficiary shall survive the Participant, the death benefits payable shall be payable per the Plan document.

I hereby direct that any and all death benefits payable under the terms of the Plan be payable to the following Beneficiaries in accordance with the following provisions. Any and all previous Beneficiary Designations are hereby revoked.

Beneficiary #1

	Name	Date of Birth	Relationship	SSN	Percent
Primary #1					%

If this primary beneficiary does not survive me, upon my death the proceeds that would otherwise have gone to the primary beneficiary should go to the following secondary beneficiary(ies).

Secondary					%
Secondary					%

Beneficiary #2

	Name	Date of Birth	Relationship	SSN	Percent
Primary #2					%

If this primary beneficiary does not survive me, upon my death the proceeds that would otherwise have gone to the primary beneficiary should go to the following secondary beneficiary(ies).

Secondary					%
Secondary					%

Beneficiary #3

	Name	Date of Birth	Relationship	SSN	Percent
Primary #3					%

If this primary beneficiary does not survive me, upon my death the proceeds that would otherwise have gone to the primary beneficiary should go to the following secondary beneficiary(ies).

Secondary					%
Secondary					%

Consent

If you are currently married and have named **any** primary beneficiary other than your spouse, the following consent must be signed by your spouse and witnessed by a plan representative or a notary public. If your marital status changes, that may automatically change your beneficiary designation under the terms of the Plan and you should file a new beneficiary designation form.

I consent to the beneficiary designation above: _____ Signature of Participant's Spouse _____ Date

This instrument was signed before me on _____ Date, _____ Plan Representative or Notary Public

Sign

I understand that the above beneficiary designation will remain in force until I request a change in accordance with the provisions of the Plan.

_____ Participant _____ Date