



**Cascade Healthcare Services, LLC 401(k) Plan  
CONTRIBUTION FORM**

I, \_\_\_\_\_, hereby acknowledge and understand that as a Participant in Cascade Healthcare Services, LLC 401(k) Plan, I may reduce my salary up to a maximum amount permitted by law. I further understand that any amounts I may defer hereunder shall be deducted from my paycheck by my employer and deposited into my accounts under the Plan by the Plan's Trustees.

- **In accordance with my rights as a Participant and provisions of the Plan, I hereby elect to reduce my pay by \_\_\_\_\_% each pay period.**
- **In accordance with my rights as a Participant and provisions of the Plan, I hereby elect to "Opt out" by making no contribution at all.**

This election authorizes my Employer to withhold this amount from my paycheck. This election shall remain in effect until I revoke this election in writing or change my election percentage or amount in accordance with the rules of the Plan. Any questions regarding this election should be directed to the Plan Administrator.

Salary Deferral elections may be made effective on the first day of each calendar month.

I understand that this election will be implemented as soon as administratively feasible but no later than 30 days from its receipt by the Employer.

I understand that the Plan Administrator may limit my salary reduction contributions during the year if doing so will enable the Plan to meet the various Internal Revenue Code and Regulation provisions affecting the Plan.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Social Security Number

**Cascade Healthcare Services, LLC 401(k) Plan  
BENEFICIARY DESIGNATION**

As a Participant in Cascade Healthcare Services, LLC 401(k) Plan, I, \_\_\_\_\_, hereby acknowledge that the Plan Administrator has informed me that should I die before retirement, my Vested Benefit shall be paid to my spouse, provided we have been married for at least one year at the time of my death.

Check applicable provision

- o If my spouse does not survive me, I direct that my benefit be paid in equal shares to such of my children as shall be living at my death, except that the then living descendants of a deceased child of mine shall take per stirpes the share which the child would have received if living. I intend that this provision provide for all my children, including any hereafter born or adopted.
- o If my spouse does not survive me, I direct that my benefit be paid in equal shares to such of my children as shall be living at my death. (per capita) I intend that this provision provide for all my children, including any hereafter born or adopted.
- o If my spouse does not survive me, I direct that my benefit be paid to my Beneficiaries in the shares designated below.
- o As of the date of this designation, I hereby certify that I am not currently married and designate the following person(s) as my Beneficiary(ies) in the event I die before I retire. I understand that this Designation shall be automatically revoked if I marry between now and my death or retirement from the Plan, and my Vested Benefit shall be paid to my spouse, provided we have been married for at least one year at the time of my death. I may, at that time and with the consent of my spouse, execute a waiver of my spouse as my designated Beneficiary and name a new Beneficiary in place thereof.
- o With the consent of my spouse, \_\_\_\_\_, I have appointed the following Primary Beneficiaries:

**Primary Beneficiaries:**

**Spouse's  
Initials**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Percentage of total benefit to be paid to the above person \_\_\_\_\_%.

[     ]

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Percentage of total benefit to be paid to the above person \_\_\_\_\_%.

[     ]

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Percentage of total benefit to be paid to the above person \_\_\_\_\_%.

[     ]

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Percentage of total benefit to be paid to the above person \_\_\_\_\_%.

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