Former Participant Claim Form

Schave v. CentraCare Health System, et al., Case No. 0:22-cv-01555-JRT/LIB

If you were a participant in CentraCare Health System Retirement Plan or the CentraCare Health System 403(b) Plan during the period from June 13, 2016 through May 17, 2024 (the Class Period), but you did not have an account with a positive balance in either Plan as of May 17, 2024; or if you are a Beneficiary or Alternate Payee (in the case of a person subject to a Qualified Domestic Relations Order) of such a participant, *and* you would prefer to have your settlement proceeds rolled over into an eligible retirement plan, you must complete this form and mail it WITH A POSTMARK ON OR BEFORE AUGUST 12, 2024 to the following address:

Schave v CentraCare Health System, et al.
c/o Atticus Administration
PO Box 64053
St. Paul, MN 55164

For purposes of this Former Participant Claim Form, Former Participant means a person who did not have an account with a positive balance in either Plan as of May 17, 2024; Beneficiary and Alternate Payee respectively mean a Beneficiary or Alternate Payee of a Former Participant.

- **Participant Information**

Your Name		
Address		
Address 2		
City	State	Zip
Your Social Security Number	Phone (Preferred)	Phone (Alternate)
Your Date of Birth		
Email Address		
Claimant ID:		

- **Beneficiary or Alternate Payee Information (<u>ONLY PROVIDE IF THIS PERSON SHOULD RECEIVE PAYMENT INSTEAD OF THE PARTICIPANT)</u>**

Your Name		
Address		
Address 2		
City	State	Zip
Your Social Security Number	Phone (Preferred)	Phone (Alternate)

Your Date of Birth
Email Address

BY SUBMITTING THIS FORM, I DIRECT THAT IF PRACTICABLE, MY PAYMENT SHALL BE MADE PAYABLE TO AS A ROLLOVER DISTRIBUTION TO THE FOLLOWING RETIREMENT ACCOUNT:

Account Name	
Account Number	
Contact or Trustee (if required)	
Address Line 1	
Address Line 2	
City, State, ZIP	

BY SUBMITTING THIS FORM, I FURTHER CERTIFY AND REPRESENT UNDER PENALTY OF PERJURY THAT NO PORTION OF THE PAYMENT TO BE ROLLED OVER IS SUJBECT TO A QUALIFIED DOMESTIC RELATIONS ORDER (QDRO) OR ALTERNATIVELY, THAT A TRUE AND ACCURATE COPY OF ANY APPLICABLE QDRO IS ENCLOSED AND THAT THE REQUESTED ROLLOVER IS CONSISTENT WITH THAT QDRO.

Signature (Required): ___________________________________ **Date:** _________________________

Note: There is no promise or assurance your payment is 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 assistance or advice of any kind regarding this issue or other tax considerations.

Deceased Class Members are not eligible for rollover treatment and cannot use this form. For further inquiries, please contact the Settlement Administrator or Class Counsel.