# OAE–Meritec 401K Enrollment / Contribution / Change Form

MERITEC® Innovative-Interconnect Solutions

Associated Enterprises / Meritec

## Changes can be made by currently enrolled employees at the beginning of each quarter.

Employee Name (Please Print) _____

Date Requested _____

Percentage Change _____

Dollar Amount Change _____

Effective Payroll Date _____

## 401K ELECTIONS

### Please check only one response and return to Brenda Rife

- ◯ I am currently enrolled in the 401K Plan and do not wish to change anything at this time. Beneficiary Form (below).
- ◯ I am currently enrolled in the 401K Plan and wish to make changes. Application is attached and Beneficiary Form (below).
- ◯ I am currently enrolled in the 401K Plan but not participating – I wish to join at this time. Application is attached and Beneficiary Form (below).
- ◯ I am currently enrolled in the 401K Plan, but not actively participating. Beneficiary Form (below).
- ◯ I would like to enroll as a New Member of the 401K Plan. My New Application is attached and Beneficiary Form (below).
- ◯ I am currently enrolled in the 401K Plan and wish to discontinue contributions at this time. Beneficiary Form (below).
- ◯ I do not wish to participate in the 401K Plan at this time.

Attachment(s): _____

LIFE INSURANCE INFO.

COMPLETE INFORMATION BELOW FOR YOUR 401K BENEFICIARY (ies)

| Primary Beneficiary Name(s) – Must Add Up To 100% | Relationship | % Benefit | Phone | Address |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| Optional Contingent/Secondary Beneficiary Name(s) | Relationship | % Benefit | Phone | Address |
| | | | | |

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by the Plan; (b) to be eligible for coverage, I must be an active eligible participant as defined by the policy(ies); (c) to be eligible for life and or disability income insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my life and/or disability coverage will begin on the day I return to work; (d) if coverage is issued, it will be based on full reliance on the information contained in this Application.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy or electronic reproduction of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that my dependents and myself are hereby eligible for coverage after review of the Plan's eligibility parameters. All information that I have provided is true and complete to the best of my knowledge.

Furthermore, I understand that if no coverage has been elected or I have selected a waiver, I hereby refuse the Plan offered by my employer and recognize that my future enrollment may be subject to certain restrictions as defined by the Plan. By enrolling, I authorize payroll deductions that are required for the benefits that I elect. I understand that my elections are irrevocable unless I have a Qualified Status Change. In addition, I understand that the benefits for which I have enrolled may not be immediately available or available to me based on eligibility exclusions, limitations or waiting periods and final coverage requires certification by human resources before is shall be activated.

_____ Employee Signature

_____ Date

**ASSOCIATED ENTERPRISES** • 1382 WEST JACKSON STREET • POST OFFICE BOX 110 • PAINESVILLE, OHIO 44077

PHONE: (440) 354-2106 • FAX: (440) 354-0687 • WWW.MERITEC.COM • E-MAIL: INFO@MERITEC.COM