



# Participant Enrollment

Mid-Atlantic Home Health Network 401(k) Plan

397532-01

## Participant Information

Last Name			First Name			MI		
Address - Number & Street								
City			State			Zip Code		
( )								
Daytime Phone								
Social Security Number								
E-Mail Address								
Mo			Day			Year		
Date of Birth								
<input type="checkbox"/> Married <input type="checkbox"/> Unmarried								

## Payroll Information

The amount that you may contribute is 1% - 100% OR \$1.00 - \$15,000.00 of your compensation, whichever is less. The amount that you may contribute is not to exceed the annual maximum contribution allowable under the Internal Revenue Code and applicable regulations and/or the provisions of your Plan.

I elect to contribute \_\_\_\_\_% or \$\_\_\_\_\_ (do not complete both) (per pay period) of my compensation as before-tax contributions to the 401(k) Plan until such time as I revoke or amend my election.

Payroll Effective Date: \_\_\_\_\_  
Mo Day Year

Date of Hire: \_\_\_\_\_  
Mo Day Year

**Investment Option Information (applies to all contributions)** - Please refer to your enrollment materials for information regarding each investment option.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure documents for more information.

See Participation Agreement and the Required Signature sections

<u>Investment Option Name</u>	<u>Investment Option Code</u>	<u>Investment Option Name</u>	<u>Investment Option Code</u>
Fidelity Advisor Treasury Fund - C	FDCXX	Fidelity Advisor New Insights C	FNICX
Fidelity Advisor Intermediate Bond - C	FNBCX	Fidelity Advisor Mid Cap - C	FMCEX
Fidelity Advisor Strategic Income Fund C	FSRCX	Fidelity Advisor Small Cap Fund C	FSCEX
Fidelity Advisor Balanced - C	FABCX	Fidelity Advisor Diversified Int'l - C	FADCX
Fidelity Advisor Large Cap - C	FLCCX	Fidelity Advisor Overseas Fund - C	FAOCX
Fidelity Advisor Equity Growth Fund - C	EPGCX	Fidelity Advisor Natural Resources C	FNRCX
Fidelity Advisor Equity Income - C	FEICX		
Fidelity Advisor Strategic Growth - C	FTQCX		
Fidelity Advisor Growth Opportunities C	FACGX		
		<b>MUST INDICATE WHOLE PERCENTAGES</b>	<b>= 100%</b>

## Participation Agreement

**Withdrawal Restrictions** - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

**Investment Option Information** - I understand that by signing and submitting this Participant Enrollment form for processing, I am requesting to have investment options established under the Plan as specified in the Investment Option Information section. I understand and agree that this account is subject to the terms of the Plan Document. I understand and acknowledge that all payments and account values, when based on the experience of the investment options, may not be guaranteed and may fluctuate, and, upon redemption, shares may be worth more or less than their original cost. I acknowledge that investment option information, including prospectuses, and disclosure documents, have been made available to me and I understand the risks of investing.

**Plan Fees** - I understand that fees may apply under this Plan.



# Participant Enrollment

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Last Name	First Name	MI	Social Security Number
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**Compliance With Plan Document and/or the Code** - I agree that my employer or Plan Administrator may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

**Incomplete Forms** - I understand that in the event my Participant Enrollment form is incomplete or is not received by my employer prior to the receipt of any deposits, I specifically consent to Service Center retaining all monies received and allocating them to the default investment option selected by the Plan. If no default investment option is selected, funds will be returned to the payor as required by law. Once an account has been established on my behalf, I understand that I must call 1-888-365-2926 or access the Web site in order to request a transfer of monies from the default investment option. Also, I understand all contributions received after an account is established on my behalf will be applied to the investment options I requested.

**Account Corrections** - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Center of an error after this 90 days, the correction will only be processed from the date of notification forward and not on a retroactive basis.

**Required Signature** - I have completed, understand and agree to all pages of this Participant Enrollment form.

Participant Signature

Date

Participant forward to:  
Plan Administrator



# Salary Deferral Agreement

Mid-Atlantic Home Health Network 401(k) Plan

397532-01

## Participant Information

_____	_____	_____
Last Name	First Name	MI
_____		
Address - Number & Street		
_____	_____	_____
City	State	Zip Code
( ) _____		
Daytime Phone		

_____		
Social Security Number		
_____		
E-Mail Address		
Mo	Day	Year
_____	_____	_____
Date of Birth		
<input type="checkbox"/>	Married	<input type="checkbox"/>
		Unmarried

## Salary Deferral Agreement

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superceded, or the employee ceases to be an eligible employee. This Agreement supercedes all previous agreements.

I understand that I may change the percentage of compensation or dollar amount contributed to the Plan only when and as allowed under the terms of the Plan. I also understand that it is my responsibility to comply with the Internal Revenue Code (the "Code") deferral limits; that any excess contributions will be distributed pursuant to Treasury regulation 1.402(g)-1, as amended; and that I may be responsible for any costs, including taxes and penalties, that I may incur as a result of such excess contributions.

### Payroll Information - Specify one of the following:

- New Enrollment    
 Restart    
 Increase Payroll Deduction    
 Decrease Payroll Deduction    
 Stop Deductions

Specify the following:

The amount that you may contribute is 1% - 100% OR \$1.00 - \$15,000.00 of your compensation, whichever is less. The amount that you may contribute is not to exceed the annual maximum contribution allowable under the Code and applicable regulations and/or the provisions of your Plan.

- I elect to contribute \_\_\_\_\_% or \$\_\_\_\_\_ (do not complete both) (per pay period) of my compensation as before-tax contributions to the 401(k) Plan until such time as I revoke or amend my election.

Payroll Effective Date: \_\_\_\_\_

Mo Day Year

Date of Hire: \_\_\_\_\_

Mo Day Year

## Required Signature

I have completed, understand and agree to the terms of this Agreement and authorize the payroll deduction as indicated on this form.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

Participant forward to:  
Plan Administrator





# Beneficiary Designation

Mid-Atlantic Home Health Network 401(k) Plan

397532-01

## Participant Information

Last Name	First Name	MI	Social Security Number
E-Mail Address			<input type="checkbox"/> Married <input type="checkbox"/> Unmarried

## Account Extension

An account extension identifies funds that were transferred to a spousal beneficiary or alternate payee due to divorce or death. If you have an account extension, enter it here \_\_\_\_\_. For assistance, please contact Service Center at: 1-888-365-2926.

## Plan Beneficiary Designation

This designation is effective upon execution and delivery to the Plan Administrator. If I name more than one beneficiary in either category, the surviving beneficiaries in that category will share equally unless otherwise indicated. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable state law.

**This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. Primary and contingent beneficiaries must separately total 100.00%. The number of primary or contingent beneficiaries you may name is not limited. Attach an additional sheet, if necessary.**

### Primary Beneficiary

#1	_____	_____	_____	_____	_____
	% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
#2	_____	_____	_____	_____	_____
	% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
#3	_____	_____	_____	_____	_____
	% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth

### Contingent Beneficiary

#1	_____	_____	_____	_____	_____
	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
#2	_____	_____	_____	_____	_____
	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
#3	_____	_____	_____	_____	_____
	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth



# Beneficiary Designation

_____	_____	_____	_____
Last Name	First Name	MI	Social Security Number

## Spousal Consent

Important Notice: If you are married and the Plan is subject to spousal consent requirements under ERISA and/or the Plan Document, you must have your spouse's signature notarized or have the Plan Administrator witness your spouse's signature to designate a primary beneficiary other than your spouse, or in addition to your spouse. **The date your spouse signs below must match the date on which his or her signature was notarized or witnessed.**

**Spouse's Notarized Consent:** I hereby consent to the above beneficiary designation and understand its effect. I understand that I may be waiving my right to receive a survivor annuity which would otherwise be payable to me.

_____	_____
Spouse's Signature	Date

### Statement of Notary

SEAL

State of \_\_\_\_\_ ) The consent to this beneficiary designation was subscribed before me by  
                                  )ss. \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_,  
County of \_\_\_\_\_ ) who affirmed that such consent represents his/her free and voluntary act.  
Address: \_\_\_\_\_  
Notary Public \_\_\_\_\_ My commission expires \_\_\_\_\_

OR

### Statement of Plan Administrator

The spouse whose signature I have witnessed is known to me and signed this form in my presence.

_____	_____
Plan Administrator Signature	Date

**Required Signatures** - I have completed, understand and agree to all pages of this Beneficiary Designation form. I understand that Service Center is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Center cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at: <http://www.ustreas.gov/offices/eotffc/ofac>.

_____	_____
Participant Signature	Date

_____	_____
Authorized Plan Administrator Signature	Date

Participant forward to Plan Administrator