NorthShore University HealthSystem

Tax Deferred Annuity Plan Settlement Administrator
P.O. Box 2007
Chanhassen, MN 55317-2007
www.NorthshoreERISA.com

## FORMER PARTICIPANT CLAIM FORM

If you were a participant in a defined contribution 403(b) retirement plan known as the NorthShore University HealthSystem Tax Deferred Annuity Plan (the "Plan") on or after May 16, 2016 through April 4, 2025 (the "Class Period"), but you do not have an Active Account with the Plan, or are a Beneficiary or Alternate Payee (in the case of a person subject to a Qualified Domestic Relations Order) of a Former Participant, and would like to receive a payment from the *Remied, et al. v. NorthShore University HealthSystem et al.* Settlement, you must complete the form below and mail it to NorthShore University HealthSystem Tax Deferred Annuity Plan Settlement Administrator, P.O. Box 2007, Chanhassen, MN 55317-2007, to be received NO LATER THAN AUGUST 2, 2025.

"Active Account" means an individual account in the Plan with a balance greater than \$0. "Former Participant" means a person who had an Active Account with a positive balance in the Plan during the Class Period but who did not have an account with the Plan with a balance greater than \$0 as of April 4, 2025. "Beneficiary" or "Alternate Payee" means, for the purposes of this Former Participant Claim Form, a Beneficiary or Alternate Payee of a participant in the Plan who maintained a positive account balance in the Plan at some point during the Class Period, but who no longer had an Active Account in the Plan as of April 4, 2025.

PARTICIPANT INFORMATION									
First Name	Middle Last Name								
Mailing Address									
City	State Zip Code								
Phone (Preferred)	Phone (Alternate)								
Email Address									
Participant's Social Security Number	Participant's Date of Birth								
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## BENEFICIARY OR ALTERNATE PAYEE INFORMATION (ONLY PROVIDE IF THIS PERSON SHOULD RECEIVE PAYMENT INSTEAD OF THE PARTICIPANT)

Your First Name	Middle Last Name									
Your Mailing Address										
City		State Zip Code								
Phone (Preferred)  Phone (Alternate)										
		]								
Your Email Address		•								
Your Social Security Number	Your Date of Birth									
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PAYMENT EL	ECTION (CHOOSE ONLY ONE)									
I WANT A CHECK MADE PAYABLE TO ME AN withholding 20% or more of your total payment Name and Address listed above.										
<u>OR</u>										
☐ I WANT A CHECK MADE PAYABLE TO MY RE	TIREMENT ACCOUNT AS A ROLLOVER	DISTRIBUTION, PLEASE MAKE								
THE CHECK PAYABLE TO:										
Account Name										
Account Number										
Contact or Trustee (if required)										
Course and a Transfer of Address of										
Company or Trustee's Address										
Company or Trustee's City		State Zip Code								

NOTE: There is no promise or assurance that these funds are 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 with assistance or advice of any kind in this regard or answer any tax questions.

## **SIGNATURE**

Required Certification Regarding Qualified Domestic Relations Order ("QDRO"): I hereby certify and represent under penalty of perjury that no portion of the payment to be received hereunder is subject to a QDRO, or, that a true, accurate, and current copy of any applicable QDRO is attached hereto along with the name and address of any payee other than the Class Member. Payment will be made in accordance with any QDRO supplied.

Signature (Required)	Da	ite S	Sia	ned	(Re	au	ire	d)		
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## **Deceased Class Members**

Deceased Class Members are not eligible for rollover treatment. A Beneficiary of a deceased person who was a participant in the Plan at any time during the Class Period, including executors, heirs, assigns, estates, personal representatives, or successors-in-interest, must provide the following information with this Former Participant Claim Form to NorthShore University HealthSystem Tax Deferred Annuity Plan Settlement Administrator, P.O. Box 2007, Chanhassen, MN 55317-2007:

- Evidence that such person is authorized to receive distribution of the deceased Class Member's settlement payment, and the name and, if applicable, the percentage entitlement of each person entitled to receive distribution;
- Social Security Number of each person entitled to receive payment;
- Current mailing address of each person entitled to receive payment; and
- Person(s) to whom check(s) should be made payable, and amount(s) of check(s).