ThedaCare, Inc. Retirement and 403(b) Savings Plan
Settlement Administrator
P.O. Box 2007
Chanhassen, MN 55317-2007
www.ThedaCareERISA.com

## FORMER PARTICIPANT CLAIM FORM

If you were a participant in a defined contribution 403(b) retirement plan known as the ThedaCare, Inc. Retirement and 403(B) Savings Plan (the "Plan") on or after August 12, 2014 through November 14, 2024 (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 *Glick v. ThedaCare, Inc.* et al. Settlement, you must complete the form below and mail it to ThedaCare, Inc. Retirement and 403(B) Savings Plan Settlement Administrator, P.O. Box 2007, Chanhassen, MN 55317-2007 to be received NO LATER MARCH 14, 2025.

"Active Account" means an individual investment 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 November 14, 2024. "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 during the Class Period, but did not have an active account in the Plan as of November 14, 2024.

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	
		$\Box$
Your Mailing Address		_
		$\neg$
City	State Zip Code	_
		$\neg$
Phone (Preferred)	Phone (Alternate)	_
Your Email Address		
Your Email Address		$\neg$
Your Social Security Number	Your Date of Birth	
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PAYMENT E	ELECTION (CHOOSE ONLY ONE)	
	AND MAILED TO ME. Choosing this option entails the Settlement Administra ent for tax withholdings. The Settlement Administrator will mail your check to t	
☐ I WANT A CHECK MADE PAYABLE TO MY R THE CHECK PAYABLE TO:	RETIREMENT ACCOUNT AS A ROLLOVER DISTRIBUTION. PLEASE MAI	
Account Name		ΚE
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Account Number  Contact or Trustee (if required)		KE
Contact or Trustee (if required)		KE
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Contact or Trustee (if required)		
Contact or Trustee (if required)	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.

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Signature (Required)	Date Signed (Required)	

## **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 ThedaCare, Inc. Retirement and 403(B) Savings 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).