

403(b) PLAN TRANSACTION FORM

Coronavirus Related Loan Repayment Suspension Transaction Form

- Please supply the information requested below.
- Read all agreements on this form before submitting.
- Fields having an asterisk notation are required.

IMPORTANT NOTICE: Before You Sign, Read All Information on this form:

Coronavirus Related Loan Repayment Suspension Requirements

A qualified individual with an outstanding loan as of March 27, 2020, and that has a payment due between March 27, 2020 and December 31, 2020 is permitted to suspend repayment for up to one year if the participant:

- is diagnosed with COVID-19; or
- has a spouse or dependent who has been diagnosed with COVID-19; or
- is experiencing adverse financial consequences as a result of being quarantined, furloughed, laid off, having work hours reduced, being unable to work due to lack of child care due to COVID-19, closing or reducing hours of a business owned or operated by the individual due to COVID-19; or
- is experiencing a reduction in pay (or self-employment income) due to COVID-19 or had a job offer rescinded or start date for a job delayed due to COVID-19; or
- has a spouse or a member of the participant's household (someone who shares the participant's principal residence) that is quarantined, furloughed or laid off, had work hours reduced due to COVID-19, unable to work due to lack of childcare due to COVID-19, had a reduction in pay (or self-employment income) due to COVID-19, or had a job offer rescinded or start date for a job delayed due to COVID-19; or
- has a spouse or a member of his/her household that owns or operates a business and was forced to reduce hours or close due to COVID 19.

Part 1: Employee Information

*Social Security Number: *First Name: MI: *Last Name:

*Address:

*City: *State: *Zip: *Date of Birth:

*Phone: *Email address:

* Please provide the full Organization Name, City and State of the employer from whose Plan you took the loan(s) on which you wish to suspend repayment:

If you would like the determination result of this request forwarded directly to the service provider from whom you secured the loan(s), please provide service provider name, address and/or fax number. If no information is provided, the determination result will be returned to you at the address above.

There is a financial advisor/representative associated with the transaction.

Sales Agent/Representative Name:

Phone: Email:

I wish the above named agent to be copied on all email communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction. (Requires agent's email address to be provided above)

Part 2: Coronavirus Related Circumstances

- Participant has been diagnosed with COVID-19
- The participant's spouse or dependent has been diagnosed with COVID-19
- The participant is experiencing adverse financial consequences as a result of being quarantined, furloughed, laid off, having work hours reduced, being unable to work due to lack of child care due to COVID-19, closing or reducing hours of a business owned or operated by the individual due to COVID-19.
- The participant is experiencing a reduction in pay (or self-employment income) due to COVID-19 or had a job offer rescinded or start date for a job delayed due to COVID-19.
- The participant has a spouse or a member of the participant's household (someone who shares the participant's principal residence) that is quarantined, furloughed or laid off, had work hours reduced due to COVID-19, unable to work due to lack of childcare due to COVID-19, had a reduction in pay (or self-employment income) due to COVID-19, or had a job offer rescinded or start date for a job delayed due to COVID-19
- The participant's spouse or a member of his/her household that owns or operates a business and was forced to reduce hours or close due to COVID 19

Part 3: Employee Signature (Mandatory)

By signing below, I hereby confirm that the information on this form is correct and complete to the best of my knowledge.

Employee Signature: Date:

PLEASE RETURN THIS FORM TO U.S. OMNI UNLESS OTHERWISE ADVISED BY YOUR EMPLOYER:

U.S. OMNI • 220 Alexander Street, Suite 400 • Rochester, NY 14607

Toll Free: (877) 544-OMNI • Fax: (585) 756-5557 Please visit our website at www.omni403b.com

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