US OMNI
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457(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- is experiencing a reduction in pay (or self-employment income) due to COVID-19 or had a job offer rescinded or start date for a job delayed due to COVID-19; or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of childcare due to COVID-19, had a reduction in pay (or self-employment income) due to COVID-19, or had a job offer rescinded or start date for a job delayed due to COVID-19; or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 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**