

## Employer

Complete this section and retain this form for your records. Do not send it to American Funds. Use the plan sponsor website, [americanfunds.com/retiresponsor](http://americanfunds.com/retiresponsor), to enter the information provided or changed below.

### Employer authorization

MCC Network Services, LLC  
Name of employer, organization or company

MCC Network Services, LLC 401K Profit Sharing Plan  
Name of plan

IRK94035  
Plan ID number

The employee named in Section 1 below is eligible to participate in the plan as of \_\_\_\_\_  
(mm/dd/yyyy)

\_\_\_\_\_  
Name of person authorized to sign for the employer (print)

\_\_\_\_\_  
Title

**X** \_\_\_\_\_  
Authorized signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

## Employee

Complete Sections 1–4, then return this form to your employer to complete the section above.

### 1 Employee information

*Please type or print clearly.*

Select one of the following: ☐ New plan enrollment ☐ Changes to existing account

\_\_\_\_\_  
Name of employee

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
SSN

\_\_\_\_\_  
Residence address (physical address required — no P.O. boxes)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
Mailing address (if different from residence address)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Date of birth (mm/dd/yyyy)

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Date of hire (mm/dd/yyyy)

\_\_\_\_\_  
Country of citizenship

**Marital status:** ☐ Married ☐ Single

## 2 Employee contributions

*Before completing this section, check with your plan to determine the available contribution options.*

☐ I authorize my employer to withhold from my wages each pay period:

Pre-tax contributions of \_\_\_\_\_% **OR** \$ \_\_\_\_\_

After-tax Roth contributions (as allowed by plan) of \_\_\_\_\_% **OR** \$ \_\_\_\_\_

After-tax non-Roth contributions (as allowed by plan) of \_\_\_\_\_% **OR** \$ \_\_\_\_\_

☐ I **DO NOT** wish to make contributions to the plan at this time.

## 3 Investment selection

*Before completing this section, check with your employer to determine the available investment options.*

**New participants:** Any contributions (payroll deferrals or rollovers) to your account made before you make your investment selection(s) or before your employer updates your account on the recordkeeping system with your selection(s) will be invested in the plan's default investment. Assets will remain in the default investment until you use your plan's website, [americanfunds.com/retire](http://americanfunds.com/retire), or call your plan's toll-free phone service at (877) 833-9322 to exchange assets into the investment(s) of your choice.

**Existing participants:** Any allocation changes will apply to future contributions **only** and will not change assets currently held in your account. Your new allocations will not be effective until your employer updates your account. You can immediately update your investment allocations and/or reallocate your current assets by using your plan's website or phone service to make the desired changes. (If you use the website or call to update your account, do not submit this form to your employer.)

Invest my contributions as follows. (Only **whole** percentages will be accepted; must total 100%.)

	Investment name	Percentage
1.	<u>American Funds AMCAP</u>	_____ %
2.	<u>American Funds EuroPacific Growth</u>	_____ %
3.	<u>American Funds Growth Fund of America</u>	_____ %
4.	<u>American Funds New Economy Fund</u>	_____ %
5.	<u>American Funds New Perspective Fund</u>	_____ %
6.	<u>American Funds SMALLCAP World Fund</u>	_____ %
7.	<u>American Funds Cap World Growth &amp; Income</u>	_____ %
8.	<u>American Funds Fundamental Investors</u>	_____ %
9.	<u>American Funds Intl Growth and Income</u>	_____ %
10.	<u>American Funds Investment Co of America</u>	_____ %

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### 3 Investment selection

(continued)

	Investment name	Percentage
11.	<u>American Funds Washington Mut Inv Fund</u>	<u>          </u> %
12.	<u>American Funds Capital Income Builder</u>	<u>          </u> %
13.	<u>American Funds Income Fund of America</u>	<u>          </u> %
14.	<u>American Funds American Balanced</u>	<u>          </u> %
15.	<u>American Funds Global Balanced</u>	<u>          </u> %
16.	<u>American Funds Amer High Income Trust</u>	<u>          </u> %
17.	<u>American Funds Bond Fund of America</u>	<u>          </u> %
18.	<u>American Funds Interm Bd Fd of America</u>	<u>          </u> %
19.	<u>American Funds Money Market Fund</u>	<u>          </u> %
20.	<u>American Funds Target date 2020</u>	<u>          </u> %
21.	<u>American Funds Target date 2025</u>	<u>          </u> %
22.	<u>American Funds Target date 2030</u>	<u>          </u> %
23.	<u>American Funds Target date 2035</u>	<u>          </u> %
24.	<u>American Funds Target date 2040</u>	<u>          </u> %
25.	<u>American Funds Target date 2045</u>	<u>          </u> %
26.	<u>American Funds Target date 2050</u>	<u>          </u> %
27.	<u>American Funds Target date 2055</u>	<u>          </u> %
28.	<u>American Funds Target date 2060</u>	<u>          </u> %
29.	<u>American Funds Target date 2065</u>	<u>          </u> %
30.	<u>American Funds Target date 2070</u>	<u>          </u> %

Total            %

### 4 Employee signature

By signing below, I acknowledge that I have authorized my employer to allocate my investments as specified in Section 2.  
I acknowledge that I have completed a beneficiary designation form.

X

Signature of employee

           /            /             
Date (mm/dd/yyyy)

## Beneficiary Designation

**Read the following information carefully before completing. Return the completed and signed form to your employer.**

The designation of a beneficiary can have important tax consequences. You are encouraged to consult your tax advisor before completing this form. You should periodically review and update your beneficiary designations as appropriate.

If you are not married at the time you designate your beneficiaries and subsequently marry, 100% of your account balance will be paid at the time of your death to the surviving spouse unless your spouse signs Section 3 of this form.

### 1 Information about you

Please type or print clearly.

Name of participant

Name of employer

-   -      
SSN of participant

-   -      
Date of birth of participant (mm/dd/yyyy)

**Marital status:**

☐ Married ☐ Single

### 2 Beneficiary designation

*If the percentages do not add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. When percentages are not indicated, the beneficiaries' shares will be divided equally. If you wish to customize your designation or need more space, attach a separate page.*

#### Primary Beneficiary(ies):

I revoke all previous designations and direct that any proceeds be distributed upon my death to the designated beneficiary(ies) below. In the event that no Primary or Contingent Beneficiaries survive me, distribute any proceeds according to the terms of the plan document.

1. Full name (include middle initial) (print) Relationship %

-   -      
SSN

-   -      
Date of birth (mm/dd/yyyy)

2. Full name (include middle initial) (print) Relationship %

-   -      
SSN

-   -      
Date of birth (mm/dd/yyyy)

3. Full name (include middle initial) (print) Relationship %

-   -      
SSN

-   -      
Date of birth (mm/dd/yyyy)

**Total** 100 %

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## 2 Beneficiary designation

(continued)

**Contingent Beneficiary:** If no Primary Beneficiary survives me, pay my benefits to the following Contingent Beneficiary(ies). If any designated Contingent Beneficiary(ies) dies before I do, that beneficiary's share will be paid according to the terms of the plan document.

1.	_____	Relationship	_____ %
	Full name (include middle initial) (print)		
	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	SSN	Date of birth (mm/dd/yyyy)	
2.	_____	Relationship	_____ %
	Full name (include middle initial) (print)		
	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	SSN	Date of birth (mm/dd/yyyy)	
3.	_____	Relationship	_____ %
	Full name (include middle initial) (print)		
	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	SSN	Date of birth (mm/dd/yyyy)	
		<b>Total</b>	<u>100</u> %

Signature:

**X** \_\_\_\_\_ / /  
Signature of participant Date (mm/dd/yyyy)

## 3 Spousal consent

*The signature of the spouse must be witnessed by either a plan representative or a notary public.*

I am the spouse of the participant named in Section 1. I irrevocably consent to the designation made by my spouse to have any death benefits paid to the named beneficiary(ies) specified in Section 2. I understand that the effect of such designation is to cause my spouse's death benefit to be paid to a beneficiary other than me, that such beneficiary designation is not valid unless I consent to it and that my consent is irrevocable unless my spouse revokes the beneficiary designation.

Full name of spouse of participant (include middle initial) (print)

**X** \_\_\_\_\_ / /  
Signature of spouse of participant Date (mm/dd/yyyy)

Either a plan representative appointed by the employer **or** a notary public must witness the signature of the spouse.

\_\_\_\_\_  
Name of plan representative (print) **X** \_\_\_\_\_  
Signature of plan representative

Sworn to and subscribed before me, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
Month Year

in the County of \_\_\_\_\_, State of \_\_\_\_\_

**X** \_\_\_\_\_ / /  
Signature of notary public Date commission expires (mm/dd/yyyy)