Retirement Plan Enrollment

American Funds®

EMPLOYER: Complete this section.

Employer authorization

Employer: Please retain this form for your records.

Name of employer, organization or company

Name of plan | Plan ID #

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

Name of signer for employer (print) | Title

X
Authorized signature | Date (mm/dd/yyyy)

EMPLOYEE: Complete Sections 1–4 and return this form to your employer.

1 Employee information

Please type or print clearly.

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

First name (print) | MI | Last | 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 **Gender:** ☐ Male ☐ Female

2 Employee contributions

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

☐ I authorize my employer to withhold from my wages each pay period:
Before-tax contributions of _____% ***OR*** $_____
Catch-up contributions of _____% ***OR*** $_____
☐ I do **not** wish to make contributions at this time.

3 Investment Selection

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

	Fund name	Percentage
1.	EuroPacific Growth Fund	____%
2.	The New Economy Fund	____%
3.	Templeton Foreign Fund R	____%
4.	The Investment Company of America	____%
5.	Washington Mutual Investors Fund	____%
6.	The Income Fund of America	____%
7.	Van Kampen Equity and Income Fund A	____%
8.	The Bond Fund of America	____%
9.	U.S. Government Securities Fund	____%
10.	American Funds Money Market Fund	____%
	Total	**100%**

Any contributions to participant accounts (conversion assets, payroll deferrals and rollovers) made before your employer updates your investment selections for your account will be invested in the plan's default fund. Assets will remain in the default fund until you use the participant website to exchange assets into the funds of your choice.

4 Employee signature

By signing below, I acknowledge that I have authorized my employer to withhold the amount specified in Section 2 from my wages. I acknowledge that I have completed a beneficiary designation form.

X _____ _____/_____/_____

Employee's signature Date (mm/dd/yyyy)

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Beneficiary Designation

Please read the following carefully before completing the "Beneficiary designation" section below.

The designation of a beneficiary can have important tax consequences. You are encouraged to consult with your tax adviser before completing this form. Neither American Funds Distributors, Inc. (AFD), Capital Bank and Trust Company (CB&T) nor any affiliate of CB&T shall be liable for any claim, loss, damage or expense arising out of or in any manner connected with a distribution pursuant to this completed Beneficiary Designation 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 employer

SSN of participant ☐☐☐-☐☐-☐☐☐☐

Name of participant

Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐

2 Beneficiary designation

If the percentages don't add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. If you wish to customize your designation or need more space, please attach a separate sheet.

I revoke all previous designations and direct that this account be distributed upon my death to the designated beneficiary(ies) below.

If a designated primary beneficiary dies prior to the owner, that primary beneficiary's share will be divided equally among the surviving primary beneficiaries. If no primary beneficiary(ies) survives the participant, benefits will be paid to the contingent beneficiary(ies).

Primary beneficiary(ies): (If you're married and naming someone other than your spouse as the primary beneficiary, Section 3 of this document must be completed.)

First name (print) | MI | Last | Relationship | %

SSN ☐☐☐-☐☐-☐☐☐☐ | Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐

First name (print) | MI | Last | Relationship | 100%

SSN ☐☐☐-☐☐-☐☐☐☐ | Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐

Contingent beneficiary(ies): (Complete only if you're naming a primary beneficiary above.)

First name (print) | MI | Last | Relationship | %

SSN ☐☐☐-☐☐-☐☐☐☐ | Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐

First name (print) | MI | Last | Relationship | 100%

SSN ☐☐☐-☐☐-☐☐☐☐ | Date of birth (mm/dd/yyyy) ☐☐-☐☐-☐☐☐☐

Signature:

X _____ Participant's signature

Date (mm/dd/yyyy) ___/___/___

Continue on next page.

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Beneficiary Designation

3 Spousal consent

By signing this spousal consent, I verify that I am the spouse of the participant whose name appears on this form. I understand that my spouse has chosen to name someone other than me as the sole primary beneficiary under this plan and that this designation is not valid without my irrevocable consent. I hereby irrevocably consent to the beneficiary designation on this form. I further acknowledge that my consent is irrevocable unless my spouse revokes this designation.

First name (print) _____ MI _____ Last _____

X _____ Signature _____ 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 _____ Plan representative's signature

X _____ Notary public's signature _____ State _____ County _____

Subscribed and sworn to me the _____ day of _____ Month, 20 _____

Litho in USA CGD/9128-S2632

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