For Avera Employees
(Class SD-D)

Payroll Authorization Form

CollegeAccess529℠ | Avera
invest in your children℠

This form should be used to **authorize your employer to make periodic deductions from your paycheck to your CollegeAccess 529 Plan account. (Please note: changes to existing accounts require a separate form.)**

You must allocate a minimum of $25 per portfolio per beneficiary per pay period ($50 per month). No initial contribution is necessary for payroll deduction plan accounts.

You should receive the current Plan Disclosure Statement and Participation Agreement at the same time, or preceding the time, you complete this form. Please read it carefully before you invest. This form requires the applicant to certify that he/she has read both the Plan Disclosure Statement and the Participation Agreement.

When you have completed this form and the Account Application, please send it to your Payroll or Human Resources Department. Avera Employees, regardless of their state of residence, can invest in the CollegeAccess 529 Plan For Avera Employees (Class SD-D) as long as this form is accompanied by an Account Application.

If you have questions, call your Human Resources Department or a CollegeAccess 529 Plan Investor Services Representative, toll-free, Monday–Friday, 7:30am–5:00pm Central Time, at **1-866-529-7462.**

Terms used in this application, and not otherwise defined herein, shall have the meanings defined in the Plan Disclosure Statement.

IMPORTANT: This form is used to establish a payroll deduction plan on an existing CollegeAccess 529 account. If you do not have an account established for your beneficiary, please complete the CollegeAccess 529 Account Application and send it to your Human Resources Representative along with this form.

You must allocate a minimum of $50 per portfolio per beneficiary per month. No initial contribution necessary.

PLEASE PRINT

1. Employee Information

Employee/Account Owner

First Name | Middle Initial | Last Name

Social Security Number | Date of Birth

2. Payroll Deduction Amounts/Percentages

I wish to have the following dollar amount(s) deducted from my paycheck(s).

I wish to have the total periodic deduction(s) allocated among the various Portfolios associated with each of my Designated Beneficiaries in the following percentages. The money contributed to each beneficiary will be invested into the Plan based on your current investment instructions.

Mid Month: $ _____ End of Month: $ _____

Beneficiary Name	Social Security Number	Percent
		%
		%
		%
		%
		%
		100% Total

3. Signature and Agreement of Account Owner (Employee)

By signing below, I hereby request that a Payroll Deduction Plan be established, and do agree, represent and warrant that I have read, understand and agree to the terms and conditions set forth in both the Participation Agreement attached hereto, and the current Plan Disclosure Statement. As Account Owner, I understand that I assume all investment risk of an investment in the Program, including the potential loss of principal. **I understand that in accordance with applicable state regulations, my/our account balance, if abandoned or unclaimed after a period of time specified by state law, may be transferred to the state if I do not contact Allianz Global Investors Distributors LLC. ACCOUNT OWNER AGREES THAT ANY CLAIM BY ACCOUNT OWNER OR THE DESIGNATED BENEFICIARY AGAINST THE COUNCIL, THE STATE OF SOUTH DAKOTA OR THE MEMBERS, OFFICERS AND EMPLOYEES OF THE COUNCIL OR THE STATE OF SOUTH DAKOTA MAY BE MADE SOLELY AGAINST THE ASSETS IN ACCOUNT OWNER'S ACCOUNT AND THAT ALL OBLIGATIONS HEREUNDER ARE LEGALLY BINDING CONTRACTUAL OBLIGATIONS OF THE TRUST ONLY. AS A CONDITION OF AND IN CONSIDERATION FOR THE ACCEPTANCE OF THIS AGREEMENT BY THE PROGRAM MANAGER ON BEHALF OF THE COUNCIL, ACCOUNT OWNER AGREES TO WAIVE AND RELEASE MY EMPLOYER, THE COUNCIL AND THE STATE OF SOUTH DAKOTA, AND EACH OF THE MEMBERS, OFFICERS AND EMPLOYEES OF THE COUNCIL AND THE STATE OF SOUTH DAKOTA, FROM ANY AND ALL LIABILITIES ARISING IN CONNECTION WITH RIGHTS OR OBLIGATIONS ARISING OUT OF THIS AGREEMENT OR THE ACCOUNT.**

Signature of Employee Date

Joint Owner Signature (if applicable) Date

For Employer HR Personnel

This section must be completed before this form can be processed.

Avera

Company Name Telephone (Main)

Street Address Fax Number

City State Zip Code

Payroll Contact Name Telephone (Direct)

Please select the correct branch of Avera this employee is associated with:

Plan Name	Plan ID
ALUMEND	AVERA-ALUMEND
AVERA ACCOUNTS MANAGEMENT INC	AVERA-AMI
AVERA@HOME	AVERA-@HOME
AVERA HEALTH	AVERA HEALTH
AVERA HEALTH PLANS	AVERA-HEALTH PLANS
AVERA HOLY FAMILY	AVERA-HOLY FAMILY
AVERA McKENNAN	AVERA-MCKENNAN
AVERA PRESENTATION COLLEGE	PRES-COLLEGE
AVERA PRESENTATION CONVENT	PRES-CONVENT
AVERA QUEEN OF PEACE	AVERA-QUEEN OF PEACE
AVERA SACRED HEART	AVERA-SACRED HEART
AVERA ST. ANTHONY	AVERA-ST. ANTHONY'S
AVERA ST. BENEDICT	AVERA-ST. BENEDICT
AVERA ST. LUKES	AVER-ST. LUKE'S
AVERA ST. MARY'S	AVERA-ST. MARY'S

HR Personnel: Please send completed form(s) to:

- **via U.S. Mail:** CollegeAccess 529, P.O. Box 55769, Boston, MA 02205-5769
- **overnight:** CollegeAccess 529, c/o Boston Financial Data Services, Inc., 30 Dan Road, Canton, MA 02021-2809

NOTICE: The Account is not insured by any state and neither the principal deposited nor any investment return is guaranteed by any state. Furthermore, the accounts are not insured, nor the principal or any investment return guaranteed by the federal government or any federal agency.