AMERICAN FUNDS®
From Capital Group

Retirement Plan Investment Selection/Change

Employer

Complete this section and retain this form for your records.

Employer authorization

Name of employer, organization or company

Pacific Northwest University of Health Sciences Ret — Name of plan

BRK83805 — 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 1–3, then return this form to your employer.

1 Employee information

Please type or print clearly.

Select one of the following: ☐ New investment selection ☐ Changes to existing account

Full name (include middle initial) — 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

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2 Investment Selection

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

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

Investment name	Percentage
1. American Funds EuroPacific Growth	_____%
2. American Funds Growth Fund of America	_____%
3. American Funds New Economy Fund	_____%
4. American Funds New Perspective Fund	_____%
5. American Funds New World Fund	_____%
6. American Funds SMALLCAP World Fund	_____%
7. American Funds American Mutual Fund	_____%
8. American Funds Cap World Growth & Income	_____%
9. American Funds Fundamental Investors	_____%
10. American Funds Intl Growth and Income	_____%
11. American Funds Investment Co of America	_____%
12. American Funds Washington Mut Inv Fund	_____%
13. American Funds Capital Income Builder	_____%
14. American Funds Income Fund of America	_____%
15. American Funds Amer High Income Trust	_____%
16. American Funds Bond Fund of America	_____%
17. American Funds Capital World Bond Fund	_____%
18. American Funds Short-Term Bond Fund	_____%

Continued on next page

2 Investment selection

(continued)

Investment name	Percentage
19. American Funds U.S. Government Money Market Fund	_____%
20. American Funds Target Date 2060	_____%
21. American Funds Target Date 2055	_____%
22. American Funds Target Date 2050	_____%
23. American Funds Target Date 2045	_____%
24. American Funds Target Date 2040	_____%
25. American Funds Target Date 2035	_____%
26. American Funds Target Date 2030	_____%
27. American Funds Target Date 2025	_____%
28. American Funds Target Date 2020	_____%
29. American Funds Target Date 2015	_____%
30. American Funds Target Date 2010	_____%

Total _____% **OR** $ _____

Any contributions to participant accounts (including rollovers) made before your employer updates your investment selections will be invested in the plan's default investment. Assets will remain in the default investment until you use the participant website to exchange assets into the investments of your choice.

3 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)

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Plan name: Pacific Northwest University of Health Sciences Ret
Plan ID number: BRK83805

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 **%**

Continued on next page

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. _____ _____ _____%
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 **%**

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.

_____ **X** _____
Name of plan representative (print) Signature of plan representative

Sworn to and subscribed before me, this _____ day of _____ (Month), 20_____ (Year)

in the County of _____, State of _____

X _____ ___/___/___
Signature of notary public Date commission expires (mm/dd/yyyy)