Medical City Dallas Management, LTD.
401(k) Profit Sharing Plan
CHANGE FORM

Type of Change

Name Change _____ **Address Change _____** **Contribution Amount Change _____** **Beneficiary _____**

If name change state previous last name ______________________________

Please note you may also access your account on-line at www.nationwide.com/login to change your address or your beneficiary.

Name ___________________________________ SS No. ________________ D.O.B. __________ Hire Date __________

Address (street, city, state and zip) ____

Email: ____ Phone No. ____________________

I understand I may make changes to the following elections in accordance with the provisions of the plan.

I. **CONTRIBUTIONS** (Salary reductions)

I hereby authorize the Company to make a $___________ or ___________% reduction in my compensation per pay period and contribute such amount to the plan. Max limits apply to all plans participated in for the year.

This agreement applies to amounts earned until changed by me in writing. I understand my plan sponsor may need to reduce my contribution percentage only when required to meet certain plan limits.

II. **PROFESSIONAL MANAGEMENT OPTION** – PROACCOUNT

☐ **100% FPRD** I elect active Professional Management for all contributions and accounts. I authorize the MAP Manager to invest my funds as a moderate risk investor based on my current age unless I complete a Risk Tolerance Questionnaire (provided under separate cover) indicating a customized profile. I understand my account will remain invested in the Fidelity Puritan Fund until the manager is prepared to manage my account.

If you do not wish to use ProAccount to manage your investments or you are currently managing your own account and wish to make investment changes, please access your account at www.nationwide.com/login or call 800-772-2182.

III. **BENEFICIARY DESIGNATION** – IF YOU ARE MARRIED, FEDERAL LAW REQUIRES THAT YOUR SPOUSE BE **100%** YOUR PRIMARY BENEFICIARY. IF YOU CHOOSE OTHERWISE, YOUR SPOUSE MUST COMPLETE A SPOUSAL CONSENT FORM.

PRIMARY Beneficiary ____ __________% Relationship ___________________________

Address ____ SS# _________________________________

PRIMARY Beneficiary ____ __________% Relationship ___________________________

Address ____ **TOTAL 100%** SS# _________________________________

CONTINGENT Beneficiary _____________________________________ __________% Relationship ___________________________

Address ____ SS# _________________________________

CONTINGENT Beneficiary _____________________________________ __________% Relationship ___________________________

Address ____ **TOTAL 100%** SS# _________________________________

EMPLOYEE SIGNATURE ____ Date ______________________________

Please Note: We do not accept Electronic Signatures

For questions regarding this plan, contact Participant Services at CecilCo 800-795-401k or Dallas 972-239-4059.