

**FORMER PARTICIPANT ROLLOVER FORM**

This Former Participant Rollover Form is **ONLY** for Class Members who are **Former Participants**, or the Beneficiaries or Alternate Payees of Former Participants, of the Mercy Health Corporation Employees' Retirement Plan, the Rockford Health System Retirement Plan, and the Rockford Health Physicians Retirement Plan (collectively, the "Plans"). A Former Participant is a Class Member who participated in the Plan(s) during the Class Period, but who no longer had an Active Account in any of the Plans as of September 30, 2021.

**Former Participants who would like to elect to receive their settlement payment through a rollover to a qualified retirement account must complete, sign, and mail this form with a postmark on or before April 21, 2022.** Please review the instructions below carefully. Former Participants who do not complete and timely return this form will receive their settlement payment by check, subject to applicable tax withholding. If you have questions regarding this form, you may contact the Settlement Administrator as indicated below:

Mercyhealth ERISA Settlement  
P.O. Box 2009  
Chanhassen, MN 55317-2009  
844-575-1894  
[www.MercyhealthERISA.com](http://www.MercyhealthERISA.com)

\*\*\*\*\*

**PART 1: INSTRUCTIONS FOR COMPLETING FORMER PARTICIPANT ROLLOVER FORM**

1. If you would like to receive your settlement payment through a rollover to a qualified retirement account, complete this rollover form. You should also keep a copy of all pages of your Former Participant Rollover Form, including the first page with the address label, for your records.
2. **Mail your completed Former Participant Rollover Form postmarked on or before April 21, 2022 to the Settlement Administrator at the following address:**

Mercyhealth ERISA Settlement  
P.O. Box 2009  
Chanhassen, MN 55317-2009

**It is your responsibility to ensure the Settlement Administrator has timely received your Former Participant Rollover Form.**

3. Other Reminders:
  - You must provide date of birth, signature, and a completed Substitute IRS Form W-9, which is attached as part 5 to this form.
  - If you desire to do a rollover and you fail to complete all of the rollover information in Part 4, below, payment will be made to you by check.
  - If you change your address after sending in your Former Participant Rollover Form, please provide your new address to the Settlement Administrator.
  - **Timing of Payments to Eligible Settlement Class Members.** The timing of the distribution of the Settlement payments are conditioned on several matters, including the Court's final approval of the Settlement and any approval becoming

***[FORMER PARTICIPANT ROLLOVER FORM CONTINUES ON THE NEXT PAGE]***

final and no longer subject to any appeals in any court. An appeal of the final approval order may take several years. If the Settlement is approved by the Court, and there are no appeals, the Settlement distribution likely will occur within six months of the Court's Final Approval Order.

4. **Questions?** If you have any questions about this Former Participant Rollover Form, please call the Settlement Administrator at 844-575-1894. The Settlement Administrator will provide advice only regarding completing this form and will not provide financial, tax or other advice concerning the Settlement. You therefore may want to consult with your financial or tax advisor. Information about the status of the approval of the Settlement and the Settlement administration is available on the settlement website, [www.MercyhealthERISA.com](http://www.MercyhealthERISA.com).

## PART 2: PARTICIPANT INFORMATION

First Name	M.I.	Last Name
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Mailing Address		
<input style="width: 100%;" type="text"/>		
City	State	Zip Code
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Home Phone	Work Phone or Cell Phone	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
Participant's Social Security Number	Participant's Date of Birth	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
Email Address	M M      D D      Y Y Y Y	
<input style="width: 100%;" type="text"/>		

## PART 3: BENEFICIARY OR ALTERNATE PAYEE INFORMATION (IF APPLICABLE)

- Check here if you are the **surviving spouse or other beneficiary** for the Former Participant Class Member and the Former Participant Class Member is deceased. **Documentation must be provided showing current authority of the representative to file on behalf of the deceased.** Please complete the information below and then continue on to Parts 4 and 5 on the next page.
- Check here if you are an **alternate payee under a qualified domestic relations order (QDRO)**. The Settlement Administrator may contact you with further instructions. Please complete the information below and then continue on to Parts 4 and 5 on the next page.

Your First Name	M.I.	Last Name
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Your Social Security Number or Tax ID Number	Your Date of Birth	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
Your Mailing Address	M M      D D      Y Y Y Y	
<input style="width: 100%;" type="text"/>		
City	State	Zip Code
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

**[FORMER PARTICIPANT ROLLOVER FORM CONTINUES ON THE NEXT PAGE]**

**PART 4: PAYMENT ELECTION**

**Direct Rollover to an Eligible Plan** – Check only one box below and complete the Rollover Information Section below:

- Government 457(b)                       401(a)/401(k)                       403(b)
- Direct Rollover to a Traditional IRA       Direct Rollover to a Roth IRA (*subject to ordinary income tax*)

**Rollover Information:**

Company or Trustee's Name (*to whom the check should be made payable*)

[Grid for Company or Trustee's Name]

Company or Trustee's Mailing Address 1

[Grid for Company or Trustee's Mailing Address 1]

Company or Trustee's Mailing Address 2

[Grid for Company or Trustee's Mailing Address 2]

Company or Trustee's City

State

Zip Code

[Grid for Company or Trustee's City]

[Grid for State]

[Grid for Zip Code]

Your Account Number

Company or Trustee's Phone Number

[Grid for Your Account Number]

[Grid for Phone Number Area 1]

[Grid for Phone Number Area 2]

[Grid for Phone Number Area 3]

**PART 5: SIGNATURE, CONSENT, AND SUBSTITUTE IRS FORM W-9**

UNDER PENALTIES OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA, I CERTIFY THAT ALL OF THE INFORMATION PROVIDED ON THIS FORMER PARTICIPANT ROLLOVER FORM IS TRUE, CORRECT, AND COMPLETE AND THAT I SIGNED THIS FORMER PARTICIPANT ROLLOVER FORM.

1. The Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to back up withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. person (including a U.S. resident alien).

\_\_\_\_\_  
**Former Participant Signature (Required)**

M M    D D    Y Y Y Y  
[Grid for Date Signed]

**Date Signed (Required)**

Note: If you are subject to backup withholding, you must cross out item 2 above. The IRS does not require your consent to any provision of this document other than this Form W-9 certification to avoid backup withholding.

**QUESTIONS? VISIT: [WWW.MERCYHEALTHTERISA.COM](http://WWW.MERCYHEALTHTERISA.COM), OR CALL 844-575-1894**