

**Garnet Health Medical Center 403(b) Settlement**  
**c/o Atticus Administration**  
**P.O. Box 64053**  
**Saint Paul, MN, 55164**  
**[www.GarnetHealthERISASettlement.com](http://www.GarnetHealthERISASettlement.com)**  
**ROLLOVER FORM**

In order to receive your share of the Settlement by direct rollover to a qualified individual retirement account, Class Members must complete, sign, and mail this form with a postmark on or before April 20, 2026. Please review the instructions below carefully. If you have questions regarding this form, you may contact the Settlement Administrator as indicated below:

[WWW.GARNETHEALTHERISASETTLEMENT.COM](http://WWW.GARNETHEALTHERISASETTLEMENT.COM) OR CALL +1 800-485-6615.

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**1. PART 1: INSTRUCTIONS FOR COMPLETING ROLLOVER FORM**

1. If you would like to receive your share of the Settlement by direct rollover to a qualified individual retirement account (commonly called an “IRA”) or qualified employer plan (such as a 401(k) plan), please complete this Rollover Form. You should also keep a copy of all pages of your Rollover Form, including the first page with the address label, for your records.
2. **Mail your completed Rollover Form postmarked on or before April 20, 2026 to the Settlement Administrator at the following address:**

**Garnet Health Medical Center 403(b) Settlement**  
**c/o Atticus Administration**  
**P.O. Box 64053 Saint Paul, MN, 55164**

**You also may email a completed, signed copy to [GarnetHealthERISASettlement@atticusadmin.com](mailto:GarnetHealthERISASettlement@atticusadmin.com). It is your responsibility to ensure the Settlement Administrator has timely received your Rollover Form.**

3. Other Reminders:
  - You must provide your 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 direct 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 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 final and no longer subject to an appeal 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 four months of the Court's Final Approval Order.
4. **Questions?** If you have any questions about this Rollover Form, please call the Settlement Administrator at +1 800-485-6615. The Settlement Administrator will provide advice only regarding completing this form and will not provide financial, tax or other advice concerning the Settlement or your situation. 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.GarnetHealthERISASettlement.com](http://www.GarnetHealthERISASettlement.com).

PART 2: SETTLEMENT CLASS MEMBER INFORMATION

First Name	Middle	Last Name
<div></div>	<div></div>	<div></div>
Mailing Address		
<div></div>		
City	State	Zip Code
<div></div>	<div></div>	<div></div>
Home Phone	Work Phone or Cell Phone	
<div></div>	<div></div>	
Participant's Social Security Number	Participant's Date of Birth	
<div></div>	<div></div>	
Email Address	M M D D Y Y Y Y	
<div></div>		

[ROLLOVER FORM CONTINUES ON THE NEXT PAGE]

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

- ☐ Check here if you are the **surviving spouse or other beneficiary** for the Settlement Class Member and the Settlement 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.

First Name	Middle	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address		
<input type="text"/>		
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Phone	Work Phone or Cell Phone	
<input type="text"/>	<input type="text"/>	
Participant's Social Security Number	Participant's Date of Birth	
<input type="text"/>	<input type="text"/>	
Email Address	M M	D D Y Y Y Y
<input type="text"/>		

[ROLLOVER FORM CONTINUES ON THE NEXT PAGE]

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