

Pacific Northwest University of Health Sciences (TSA) / 403(b) Investment Election Form

EMPLOYEE NAME: _____ DATE: _____

SOC SEC #: _____ DATE OF BIRTH: _____ LOCATION: _____

#1
OR
#2

_____% AMERICAN FUNDS TARGET DATE RETIREMENT SERIES
Choose your own portfolio
GROWTH FUNDS _____% AMCAP FUND – A AMCPX _____% EUROPACIFIC GROWTH FUND – A AEPGX _____% THE GROWTH FUND OF AMERICA – A AGTHX _____% THE NEW ECONOMY FUND – A ANEFX _____% NEW PERSPECTIVE FUND – A ANWPX _____% NEW WORLD FUND – A NEWFX _____% SMALLCAP WORLD FUND – A SMCWX
GROWTH-AND-INCOME FUNDS _____% AMERICAN MUTUAL FUND – A AMRMX _____% CAPITAL WORLD GROWTH AND INCOME FUND – A CWGIX _____% FUNDAMENTAL INVESTORS – A ANCFX _____% INTERNATIONAL GROWTH AND INCOME FUND – A IGAAX _____% THE INVESTMENT COMPANY OF AMERICA – A AIVSX _____% WASHINGTON MUTUAL INVESTORS FUND – A AWSHX
EQUITY INCOME FUNDS _____% CAPITAL INCOME BUILDER – A CAIBX _____% THE INCOME FUND OF AMERICA – A AMECX
BALANCED FUND _____% AMERICAN BALANCED FUND – A ABALX
BOND FUNDS _____% AMERICAN HIGH-INCOME TRUST – A AHITX _____% THE BOND FUND OF AMERICA – A ABNDX _____% CAPITAL WORLD BOND FUND – A CWBFX _____% INTERMEDIATE BOND FUND OF AMERICA – A AIBAX _____% U.S. GOVERNMENT SECURITIES FUND – A AMUSX
CASH-EQUIVALENT FUND _____% AMERICAN FUNDS MONEY MARKET FUND – A AFAXX
100% TOTAL

- I hereby authorize payroll deduction in the following amount
(\$ _____) or (% _____) per payroll period. (24 payroll periods per year.)
- I hereby elect to change the allocation of my plan investments as indicated above.
This change applies to future contributions only. To change your current balance online go to americanfunds.com/retire or call 877-833-9322. If you forget your pin call 800-421-6019.
- I do not wish to participate at this time.

*I understand that it is my responsibility to confirm the above requested allocation by reviewing the statements sent to me by the investment company.
Your retirement plan is an individual account plan that is intended to comply with Sec. 404(c) of the Employee Retirement Security Act. To the extent that you direct the investment of your account balance, you hold harmless the plan fiduciary for any loss that results from your exercise of control.
This form and the attached application need to be returned to the Payroll Department. Please put your name, address and beneficiary information on the application and sign where indicated.*

PARTICIPANT SIGNATURE: _____