

DESIGNATION OF BENEFICIARY FORM

Plan Name: Health Care Innovations, Inc. 401(k) Plan  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Plan Number: 39439

Participant Information

Note: The accompanying instructions are an integral part of this form and you should use them to assist you.

Name: Last First Middle Initial  
Address: Street  
City State Zip

Marital Status: Single [ ] Married [ ]

Primary Beneficiary

I understand that if I am married, my spouse shall automatically be my designated Beneficiary unless I elect otherwise and my spouse consents to such election. I hereby designate the following person or persons as primary Beneficiaries of my Account under the Plan payable in the event of my death.

Name: Social Security Number: Address: Date of Birth: Relationship to Participant: Percentage: (Two columns of fields)

The total of the percentages cannot exceed 100%. When more than one Beneficiary is designated, and no percentage is specified, payment will be made in equal shares to each surviving Beneficiary, or all to the last surviving Beneficiary.

Contingent Beneficiary

In the event that there are no living primary Beneficiary at my death, I hereby designate the following person or persons as contingent Beneficiaries of my Account:

Name: Social Security Number: Address: Date of Birth: Relationship to Participant: Percentage: (Two columns of fields)

The total of the percentages cannot exceed 100%. When more than one Beneficiary is designated, and no percentage is specified, payment will be made in equal shares to each surviving Beneficiary, or all to the last surviving Beneficiary.

Signatures

I reserve the right to revoke or change any Beneficiary designation. I hereby revoke all my prior designations (if any) of primary and contingent Beneficiaries.

(NOTE: IF YOU ARE MARRIED, SEE THE REVERSE SIDE OF THIS FORM FOR APPLICABLE SPOUSAL CONSENT REQUIREMENTS.)

Please return this form to the Plan Administrator after you have completed it.

PARTICIPANT \_\_\_\_\_

DATE \_\_\_\_\_

As Plan Administrator I hereby acknowledge receipt of this form.

PLAN ADMINISTRATOR  
PRINT NAME\* \_\_\_\_\_

PLAN ADMINISTRATOR  
SIGNATURE\* \_\_\_\_\_

DATE \_\_\_\_\_

*Note: The Plan Administrator will maintain possession of this form.*

If your spouse is not your Designated Primary Beneficiary, then this Designation of Beneficiary is invalid without the consent of your spouse unless your spouse waived the right to consent to any change in the beneficiary designation under a prior beneficiary designation.

**Consent of Spouse**

I acknowledge that I am the spouse of the Participant named on the reverse side of this form. I hereby certify that I have read this Designation of Beneficiary Form and understand that I possess a beneficial interest in my spouse's Account under the Plan if I survive him/her. I hereby acknowledge and consent to the Designation of Beneficiary on the reverse side of this form. My consent shall be irrevocable unless my spouse subsequently changes the Designation of Beneficiary. If my spouse changes the designation, {Choose (a) or (b)}:

- (a) I understand I must sign a new consent to the new designation for it to be effective.
- (b) I waive my right to consent to any future change in designation. I understand I have the right to restrict my consent only to the Beneficiary designated on the reverse side of this form by checking box (a).

I have executed this consent this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Participant's Spouse  
(Must be witnessed by a Plan Representative or a Notary Public)

**Plan Representation**

Signature of spouse witnessed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, in the presence of:

\_\_\_\_\_  
Plan Representative

\_\_\_\_\_  
(Print Name)

**OR**

**Notary Public**

STATE OF \_\_\_\_\_ (ss.)

COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me appeared \_\_\_\_\_ who acknowledged herself or himself to be the person who executed the consent set forth above and acknowledged the consent to be his or her free act and deed.

Notary Public \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Fidelity Investments Institutional Operations Company, Inc., P.O. Box 770001, Cincinnati, OH 45277-0018