

OBRA/PST Acknowledgement Card
 (Please complete and submit to your Payroll Center)

Plan Information

| |
|--------------------------|
| Employer Name: |
| Employer Plan Number: |
| Employer's Phone Number: |

| | |
|-------------------------|--------------------------|
| Deferral Amount* | Payroll Frequency |
| % | |

*Contributions to the OBRA Plan must be a minimum of 7.5% of compensation.

Allocation: 100% Nationwide Fixed Account

Participant Information

| | |
|--------------------------|--|
| Name: | |
| Mailing Address: | |
| | |
| City, State, & Zip Code: | |
| SS#: | Date of Birth: |
| Contact Phone: | Gender (check one): <input type="checkbox"/> M <input type="checkbox"/> F |
| Email: | |

Beneficiary Information

*If there are additional beneficiaries, please attach a separate sheet.

| | |
|----------------------------|----------------|
| Primary Beneficiary | |
| Name: | |
| Address: | |
| City, State, & Zip Code: | |
| SSN: | Date of Birth: |
| Relationship: | |

| | |
|-------------------------------|----------------|
| Contingent Beneficiary | |
| Name: | |
| Address: | |
| City, State, & Zip Code: | |
| SSN: | Date of Birth: |
| Relationship: | |

I acknowledge and understand that my participation in the plan is governed by the Plan Document and the Informational Sheet. I understand that 100% of my deferrals will be deposited in the Nationwide Fixed Account held with Nationwide Life Insurance Company.

Participant Signature

Date

Retirement Specialist

Agent #