EMPOWER

Paycheck Contribution Election
401(k) Plan

Buffalo Engine Components, Inc. Retirement Plan **769048-01**

Use black or blue ink when completing this form. For questions regarding this form, visit the Web site at empowermyretirement.com or contact Service Provider at 1-800-338-4015.

A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension

Social Security Number *(Must provide all 9 digits)*

Last Name First Name M.I.

(The name provided MUST match the name on file with Service Provider.)

( ) Daytime Phone Number

( ) Alternate Phone Number

B Payroll Election(s)

Paycheck Contribution Election *(Payroll Deductions)*

Select One: ❑ Start ❑ Restart ❑ Change ❑ Stop

I elect to contribute to the Plan the following of my eligible compensation indicated below *(per pay period)*:

❑ Deferred Salary Contributions _____% (1% - 100%)

Date of Hire *(mm/dd/yyyy)* _____/_____/_____

The total annual before-tax contributions cannot exceed $20,500.00 of my eligible compensation in the 2022 tax year.

Age 50 Catch-Up Election

I elect to contribute to the Plan additional Age 50 Catch-Up amounts of my eligible compensation as indicated below *(per pay period)*:

Payroll Effective Date *(mm/dd/yyyy)* _____/_____/_____

The total before-tax Age 50 Catch-Up amount cannot exceed $6,500.00 of my eligible compensation in the 2022 tax year. I must be age 50 or older during this calendar year and I must be currently deferring the maximum amount allowable under the Internal Revenue Code and applicable regulations and/or my Plan. If I stop my deferrals and/or do not defer the maximum amount during this calendar year, the Age 50 Catch-Up amount I have elected to contribute will not be considered a Catch-Up deferral. The Catch-Up contributions will be allocated in the same manner as my regular contributions.

❑ I elect to cancel my Catch-Up contribution election.

C Signatures and Consent *(Signatures must be on the lines provided.)*

Participant Consent *(Please sign on the 'Participant Signature' line below.)*

My signature acknowledges that I have read, understand and agree to all pages of this form and affirms that all information that I have provided is true and correct. I also understand that:

- Until cancelled, superseded or I cease to be an eligible employee, all election(s) shall apply to all eligible compensation allowed by the Plan paid from the effective date specified unless a different effective date is required under the terms of the Plan and cancels all previous elections.
- I may change the amount of compensation contributed as allowed under the terms of the Plan.
- It is my responsibility to comply with any Internal Revenue Code deferral limits and that I may be responsible for any costs, including taxes and penalties that I may incur as a result of excess contributions.
- My Plan Administrator may take any action that may be necessary to ensure that my participation is in compliance with any applicable requirement of the Plan Document and the Internal Revenue Code.
- I authorize the payroll deduction as indicated on this form.

Any person who presents false or fraudulent information is subject to criminal and civil penalties.

Participant Signature _____ **Date *(Required)*** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Last Name	First Name	M.I.	Social Security Number	769048-01 Number

C	**Signatures and Consent** *(Signatures must be on the lines provided.)*
	Authorized Plan Administrator Signature *(Please sign on the 'Authorized Plan Administrator Signature' line below.)*
	I authorize the election indicated by the participant above. **Authorized Plan Administrator Signature** _____ **Date** ***(Required)*** _____ ***A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*** **Print Full Name** _____
D	**Mailing Instructions**
	Participant forward this form to Employer **Employer DO NOT send this form to Service Provider. Please retain for your records.**