

Sentinel 403(b) Program Account Application

1. EMPLOYEE INFORMATION (Please complete all sections.)			
Employee Name		Social Security Number	
Street Address	Daytime Phone	Date of Hire	
City	State	Zip Code	Date of Birth

2. EMPLOYER INFORMATION			
Employer Name		Employer Contact Name	
Street Address		Contact Phone	
City	State	Zip Code	For Internal Use

3. SENTINEL FUNDS INVESTMENT ELECTIONS – In what fund(s) would you like to invest?
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<u>INVESTMENT OPTION</u>	<u>PERCENTAGE</u>	<u>INVESTMENT OPTION</u>	<u>PERCENTAGE</u>
Balanced A	_____ %	Mid Cap Value A	_____ %
Capital Growth A	_____ %	Short Maturity Government A	_____ %
Conservative Allocation A	_____ %	Small Company A	_____ %
Common Stock A	_____ %	Small/Mid Cap A	_____ %
Government Securities A	_____ %	Sustainable Core Opportunities A	_____ %
Growth Leaders A	_____ %	Sustainable Growth Opportunities A	_____ %
International Equity A	_____ %	U. S. Gov't Portfolio	_____ %
Mid Cap Growth A	_____ %	Total	100%

4. BROKER/DEALER or ADVISOR INFORMATION

If you do not have a Broker/Dealer or Investment Advisor, please leave this section blank.
 By this designation, I hereby authorize Sentinel Funds and its Agents to accept instructions from and transmit information to my Broker/Dealer or Investment Advisor concerning my accounts:

Name of Broker/Dealer or Advisor Firm		Dealer Number	
Registered Rep Name		Registered Rep Number	
Branch Address		Branch Number	
City	State	Zip Code	Registered Rep Phone
Dealer's Authorized Signature		Date	

Registered Investment Advisors

Firm Name	
Advisor's Name	State
Email Address	

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5. DESIGNATION OF BENEFICIARY

I hereby designate the following individual(s) as my beneficiary (ies) and request that in the event of my death, my Sentinel 403(b) Program account be distributed as indicated below. I hereby revoke all previous beneficiary designations. (Attach additional sheets if necessary.)

Primary Beneficiary(ies)

Name	Date of Birth	SSN	Relationship to Account Holder	Percentage
Street Address	City	State	Zip Code	Phone

Name	Date of Birth	SSN	Relationship to Account Holder	Percentage
Street Address	City	State	Zip Code	Phone

Secondary Beneficiary(ies)

Name	Date of Birth	SSN	Relationship to Account Holder	Percentage
Street Address	City	State	Zip Code	Phone

Name	Date of Birth	SSN	Relationship to Account Holder	Percentage
Street Address	City	State	Zip Code	Phone

6. EMPLOYEE AUTHORIZATION

Please read and sign below to open your account.

By signing this Application, I certify that I am of legal age, have received and read the current prospectus and Custodial Agreement, and agree to all terms and appoint Countybank as Custodian of my account under the Sentinel 403(b) Program.

I further certify that I have conferred with my Employer and agree that my Employer is eligible and is an employer of the type described in section 403(b)(1)(a) of the Internal Revenue Code, as amended.

Under penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number and (2) that the Internal Revenue Service has never notified me that I am subject to backup withholding, or has notified me that I am no longer subject to such withholding.

Employee Signature _____
Date

7. EMPLOYER ACCEPTANCE AND AUTHORIZATION

Signature of Employer/Sponsor or its Designee _____
Date

Send completed form to:

USI Consulting Group
Attn: Sentinel Service Team
95 Glastonbury Blvd., Suite 102
P.O. Box 6503
Glastonbury, CT 06033-6503
Phone: (866) 305-8846, Plan Code 241
Fax: (610) 537-2708

Sentinel 403(b) Program Salary Deferral Agreement

Instructions: Use this form only if your employer does not supply you with its own form.
Submit this form to your employer.

Employee Information (Please complete all sections.)			
Employee Name		Social Security Number	
Street Address	Daytime Phone	Date of Hire	
City	State	Zip Code	Date of Birth
Employer Name and Address			

Check one: New Agreement Change to previous Agreement

Salary Reduction Agreement/Election

This Agreement is effective immediately upon acceptance by the Employer, and I may modify the Agreement in accordance with procedures established by the Employer. I authorize the Employer to withhold from my salary (and treat as my deferrals) the following amount:

_____% of my salary* \$_____ per pay period*

Zero. I hereby terminate my prior Salary Reduction Agreement. [**Note:** If you have no Salary Reduction Agreement presently in effect and wish **not** to defer, do not complete this Agreement. Elect "zero" only if you wish to terminate deferrals under a prior Salary Reduction Agreement now in effect.]

*The amount of salary deferral cannot exceed the limits of Internal Revenue Code Sections 402(g), 414(v) and 415.

Employee Acknowledgement

Duty to review pay records. I understand I have a duty to review my pay records (pay stub, etc.) to confirm the Employer properly has implemented my salary reduction election. Furthermore, I have a duty to inform the Employer or its designee if I discover any discrepancy between my pay records and this Salary Reduction Agreement. I understand the Employer or its designee will treat my failure to report any withholding errors for any payroll to which my Salary Reduction Agreement applies, by the cut-off date for the next following payroll, as my affirmative election to defer the amount actually withheld (including zero). However, I thereafter may modify my deferral election prospectively, consistent with the Plan terms.

Employee Signature

Date

Employer Acceptance and Authorization

Signature of Employer/Sponsor or its Designee

Date

Sentinel 403(b) Program Request for Direct Rollover

*If you wish to have a prior employer plan account balance directly rolled into the **Sentinel 403(b) Program**, please complete this form and forward it to the administrator/custodian of the prior plan or arrangement.*

1. Prior Plan/Account Information			
Employer Name	Plan Name / Account No.		
Administrator or Contact Name	Contact Phone		
Street Address	City	State	Zip Code

2. Former Participant Information			
Name		Social Security No.	Date of Birth
Street Address		Date of Hire	Date of Termination
City	State	Zip Code	Daytime Phone:

3. Request for Direct Rollover of Plan Account
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As a former participant under the above-named plan, I hereby request a direct rollover of my entire vested account balance to the **Sentinel 403(b) Program**.

(1) Please prepare a check in the amount of my vested account balance made payable to:

Countybank, Custodian for Sentinel 403(b) Program f/b/o **[name of participant]**

(2) Please forward the above referenced check together with a copy of this form to the participant at the address listed in Part 2 above.

4. Employee Authorization

I hereby authorize the administrator of the above-named prior plan or arrangement to take such actions as are necessary and appropriate in order to effectuate the request for a direct rollover as noted above. If any additional information is required, please contact me at the telephone number listed in Part 2 above.

Signature of Former Employee/Participant

Date

Upon receipt, participant should forward check and a **Rollover Certification Form** to the Sentinel Service Team at USI Consulting Group.

Sentinel 403(b) Program Rollover Certification Form

Complete this form if you wish to have a prior employer plan account balance directly rolled into the Sentinel 403(b) Program. If you do not currently have an account established under the Sentinel 403(b) Program, you must submit a completed Account Application along with this Rollover Certification Form.

1. EMPLOYEE INFORMATION (Please complete all sections.)			
Employee Name		Social Security Number	
Street Address	Daytime Phone	Date of Hire	
City	State	Zip Code	Date of Birth

2. EMPLOYER INFORMATION			
Employer Name		Employer Contact Name	
Street Address		Contact Phone	
City	State	Zip Code	For Internal Use

3. ROLLOVER ELECTION

I elect to roll \$ _____ into the Sentinel 403(b) Program (the "Program"). Attached is a check for this amount. I understand that:

- (1) The Program is not legally required to accept a rollover.
- (2) If the Program accepts my rollover, once deposited with the Program, the rollover amount is subject to the rules of the Program concerning rollover contributions.
- (3) The amount I roll over may be subject to different tax treatment when it is ultimately distributed from the Program.

The rules regarding taxation of distributions from your rollover account are complex and vary according to your individual circumstances. You should consult with a tax advisor to determine the tax implications of your rollover.

I hereby request that the funds from my prior plan or IRA be accepted by the Custodian of the Program on my behalf, as a rollover contribution as that term is defined in the Program. I have attached either a form 1099R, a distribution statement, my last participant statement, or a letter from the prior plan or program in support of my request.

4. SENTINEL FUNDS INVESTMENT ELECTIONS – In what fund(s) would you like to invest?
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I hereby direct the Custodian of the Program to invest my rollover contributions in accordance with my current investment elections. If I do not have current investment elections in effect, or I wish to invest my rollover in a different manner, I hereby direct the Custodian to invest my rollover contributions in the following manner:

<u>INVESTMENT OPTION</u>	<u>PERCENTAGE</u>	<u>INVESTMENT OPTION</u>	<u>PERCENTAGE</u>
Balanced A	_____ %	Mid Cap Value A	_____ %
Capital Growth A	_____ %	Short Maturity Government A	_____ %
Conservative Allocation A	_____ %	Small Company A	_____ %
Common Stock A	_____ %	Small/Mid Cap A	_____ %
Government Securities A	_____ %	Sustainable Core Opportunities A	_____ %
Growth Leaders A	_____ %	Sustainable Growth Opportunities A	_____ %
International Equity A	_____ %	U.S. Government Portfolio	_____ %
Mid Cap Growth A	_____ %	Total	100%

Sentinel 403(b) Program Rollover Certification Form

5. EMPLOYEE AUTHORIZATION

Signature of Employee

Date

6. EMPLOYER ACCEPTANCE AND AUTHORIZATION

Signature of Employer/Sponsor or its Designee

Date

Send completed form to:

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