The Emory Clinic, Inc.
Deferred Compensation Plan

Vanguard Plan # 078034

Enrollment/Change

Account Information

Check one: ☐ New Enrollment ☐ Change

Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐

Name (Last, First, MI)

Address

City **State** ☐☐ **Zip** ☐☐☐☐☐

Date of birth (mm/dd/yyyy) ☐☐ – ☐☐ – ☐☐☐☐ – ☐☐☐☐

Date of hire (mm/dd/yyyy) ☐☐ – ☐☐ – ☐☐☐☐

Daytime phone # ☐☐☐ – ☐☐☐ – ☐☐☐☐

☐ Check here if address listed above is a new address.

Investment Directions

I hereby direct that all amounts withheld from my compensation be invested in the following manner. Contributions must be in increments of 1% and the total must equal 100%.

Fund Name	Allocation %	Fund Name	Allocation %

Your allocations must equal 100% 1 0 0

Beneficiary Information

Please indicate the percentage of your balance to be allocated to each beneficiary. Percentages for primary and secondary beneficiaries must each total 100%

Primary Beneficiary

Name _____
Birthdate ☐☐ – ☐☐ – ☐☐☐☐
Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐
Percentage _____ % Relationship _____

Name _____
Birthdate ☐☐ – ☐☐ – ☐☐☐☐
Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐
Percentage _____ % Relationship _____

Secondary Beneficiary (In the event your Primary Beneficiary predeceases you.)

Name _____
Birthdate ☐☐ – ☐☐ – ☐☐☐☐
Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐
Percentage _____ % Relationship _____

Name _____
Birthdate ☐☐ – ☐☐ – ☐☐☐☐
Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐
Percentage _____ % Relationship _____

Authorization

_____
Signature of Employee Date

(6/02/2003) **Please return form to Emory Clinic, Inc. Benefits Office, 101 West Ponce de Leon, Suite 400, Decatur, GA 30030** T22037_062003