

_____ % JPMorgan Small Cap Growth R6 (JGSMX)

_____ % MFS Growth R6 (MFEKX)

_____ % PIMCO Income Fund Instl (PIMIX)

_____ % T Rowe Price Diversified Mid-Cap Growth (PRDMX)

_____ % Vanguard 500 Index Adm (VFIAX)

_____ % Vanguard Interm-Term Bond Index Adm (VBILX)

_____ % Vanguard Small Cap Value Index Adm (VSIAX)

_____ % Vanguard Value Index Adm (VVIAX)

_____ % **TOTAL = 100%**

4 Required Signature

By signing below, I acknowledge that I have received and read the Summary Plan Description and the annual investment information notice. I understand that the value of investments may fluctuate over time and that there are risks associated with each investment option. I understand that the investment allocation instructions will remain in effect until I replace them by making changes through the use of the retirement plan website or voice-response system. Further, I understand that the contribution amounts will remain unchanged until I contact my Human Resources Department.

_____ **X** _____
Participant Name (print) Participant Signature Date

Return original copy of completed form to your Human Resources Department.

Plan Sponsor Authorization

_____ **X** _____
Authorized Plan Signer Name (print) Authorized Plan Signer Signature Date



BENEFICIARY DESIGNATION FORM

Highmark Companies 401(k) Profit Sharing Plan and Trust

1 Information (about you)

First Name (print)

MI Last Name

____ - ____ - _____

____ - ____ - _____

Social Security Number

Date of Birth (mm-dd-yyyy)

Marital Status: Married Single

If you are married you must name your spouse as the sole primary beneficiary unless your spouse consents in writing to you designating another Primary beneficiary. If you are not married at the time you designate your beneficiaries and subsequently marry, 100% of your vested account balance will be paid at the time of death to your surviving spouse unless your spouse consents in writing (see Section 3: Spousal Consent).

2 Beneficiary Designation

I revoke all previous designations and direct that any benefit proceeds be distributed upon my death to the designated beneficiary(ies) below. In the event that no Primary or Contingent Beneficiaries survive me, any benefit payments will be distributed according to the terms of the plan document.

X _____ Initial here if you would like to designate additional beneficiaries that do not fit within the spaces provided here. Please write the information on a separate sheet of paper. Sign and date the page, and staple it to this form.

A) PRIMARY BENEFICIARY(IES) Beneficiaries will share equally if percentages are not provided.

1. _____ %

Name (First, Middle Initial, Last)

Relationship

____ - ____ - _____

____ - ____ - _____

Social Security Number

Date of Birth (mm-dd-yyyy)

Mailing Address

City

State

Zip

Phone Number

Email Address

2. _____ %

Name (First, Middle Initial, Last)

Relationship

____ - ____ - _____

____ - ____ - _____

Social Security Number

Date of Birth (mm-dd-yyyy)

Mailing Address

City

State

Zip

Phone Number

Email Address

PRIMARY BENEFICIARY(IES) TOTAL = 100%

4 Required Signature

Subject to the spousal consent requirements, I understand that I may revoke or change this designation at any time by filing a new designation of beneficiary with the Employer, and that by doing so, I revoke all prior designations.

_____ X _____
Participant Name (print) Participant Signature Date

Return original copy of completed form to your Human Resources Department.

Plan Sponsor Authorization

_____ X _____
Authorized Plan Signer Name (print) Authorized Plan Signer Signature Date