Payroll Authorization Form
for Allianz Global Investors Affiliate Company Employees (Class SD-A)

CollegeAccess529 | Allianz Global Investors

Plan Group ID: Allianz-DR

Terms used in this application, and not otherwise defined herein, shall have the meanings defined in the Plan Disclosure Statement.

This form should be used to **authorize your employer to make periodic deductions from your paycheck, change how your payroll contributions are allocated amongst your beneficiaries, and stop payroll deduction to your CollegeAccess 529 Plan account. To make changes to your account other than those that pertain to payroll deduction, you must complete a Change Form. If you are establishing a new CollegeAccess 529 Plan account, please also include an Account Application. Confirm with your Human Resources Department that they participate in payroll deduction before completing. When you have completed the appropriate forms, please submit to your Human Resources Department (Benefits Team).**

By enrolling with your employer's Payroll Deduction Plan, you qualify to purchase at net asset value (NAV). If you have questions, call your Human Resources Department, or a CollegeAccess 529 Plan Investor Services Representative, toll-free, Monday–Friday, 8:30am–6:00pm Eastern Time, at **1-866-529-7462.**

IMPORTANT: This form is used to establish a payroll deduction plan on an existing CollegeAccess 529 account. If you do not have an account established for your beneficiary, please complete the Allianz Employee Account Application and send it to your Human Resources Representative along with this form.

PLEASE PRINT

1. Employee Information

Employee /Account Owner

First Name | Middle Initial | Last Name

Social Security Number | Date of Birth

2. Payroll Deduction Instructions

You must allocate a minimum of $50 per portfolio per beneficiary per month. No initial contribution necessary.

☐ Start payroll deductions ☐ Change deduction amount ☐ Stop payroll deductions

I wish to have the following dollar amount(s) deducted from my paycheck(s).

☐ Mid Month: $ ______________ ☐ End of Month: $ ______________

Please note, if you are a Fireman's Fund employee, indicate the amount to be deducted from your paycheck below.

☐ Per Pay Period: $______________

If you would like to change your investment option allocations, please complete the CollegeAccess 529 Change Form.

I wish to have the total periodic deduction(s) allocated among the various Portfolios associated with each of my Designated Beneficiaries in the following percentages. The money contributed to each beneficiary will be invested into the Plan based on your current investment instructions.

Beneficiary Name	Social Security Number	Percent
		%
		%
		%
		%
		%
	Total*	100%

* Allocations must be designated in whole percentages and total 100%.

3. Signature and Agreement of Account Owner (Employee)

By signing below, I hereby request that a Payroll Deduction Plan be established, and do agree, represent and warrant that I have read, understand and agree to the terms and conditions set forth in both the Participation Agreement and the current Plan Disclosure Statement. As Account Owner, I understand that I assume all investment risk of an investment in the Program, including the potential loss of principal. **I understand that in accordance with applicable state regulations, my/our account balance, if abandoned or unclaimed after a period of time specified by state law, may be transferred to the state if I do not contact the CollegeAccess 529 Plan. ACCOUNT OWNER AGREES THAT ANY CLAIM BY ACCOUNT OWNER OR THE DESIGNATED BENEFICIARY AGAINST THE COUNCIL, THE STATE OF SOUTH DAKOTA OR THE MEMBERS, OFFICERS AND EMPLOYEES OF THE COUNCIL OR THE STATE OF SOUTH DAKOTA MAY BE MADE SOLELY AGAINST THE ASSETS IN ACCOUNT OWNER'S ACCOUNT AND THAT ALL OBLIGATIONS HEREUNDER ARE LEGALLY BINDING CONTRACTUAL OBLIGATIONS OF THE TRUST ONLY. AS A CONDITION OF AND IN CONSIDERATION FOR THE ACCEPTANCE OF THIS AGREEMENT BY THE PROGRAM MANAGER ON BEHALF OF THE COUNCIL, ACCOUNT OWNER AGREES TO WAIVE AND RELEASE MY EMPLOYER, THE COUNCIL AND THE STATE OF SOUTH DAKOTA, AND EACH OF THE MEMBERS, OFFICERS AND EMPLOYEES OF THE COUNCIL AND THE STATE OF SOUTH DAKOTA, FROM ANY AND ALL LIABILITIES ARISING IN CONNECTION WITH RIGHTS OR OBLIGATIONS ARISING OUT OF THIS AGREEMENT OR THE ACCOUNT.**

Signature of Employee or Account Owner　　　　Date

Joint Owner Signature (if applicable)　　　　Date

This section must be completed before this form can be processed.

For Employer HR Personnel

Approved:

Human Resources Representative (Print Name)

X

Human Resources Representative　(Signature)　　Date

Business Unit　　Location

	Dealer No.	Branch No.
☐ Allianz Affiliate Company	888885	AFFCO
☐ Allianz Asset Management of America L.P.	888885	0100
☐ Allianz Global Investors of America L.P.	888885	0106
☐ Allianz Life	888885	US0009
☐ Pacific Investment Management Co. LLC	888885	0200
☐ Questar Capital	206211	4160821
☐ Questar Capital	206211	4945461

HR Personnel: Please send completed form(s) to:

- **via U.S. Mail:** CollegeAccess 529, P.O. Box 219337, Kansas City, MO 64121-9337
- **overnight:** CollegeAccess 529, 430 W 7th Street STE 219337, Kansas City, MO 64105-1407

NOTICE: The Account is not insured by any state and neither the principal deposited nor any investment return is guaranteed by any state. Furthermore, the accounts are not insured, nor the principal or any investment return guaranteed, by the federal government or any federal agency