



Please mail this form to Duke Benefits



Scudder Investments

Duke University 403(b) Plan

Participant New Account Form

1. PARTICIPANT INFORMATION: (Please print or type)

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
 \_\_\_\_\_ Plan Entry Date: \_\_\_\_\_

Check one:  Biweekly Employee **OR**  Monthly Employee

2. INVESTMENT INSTRUCTIONS:

Invest my total plan contributions in the investment options selected below:

	<u>Scudder Fund Name</u>	<u>% to Fund</u>
<b>FOR SCUDDER FUNDS ONLY</b>	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
(The percentage allocation must equal 100%)	<b>100%</b>	

*By this application, my employer and I direct the Custodian to open a separate Custodial Investment Account for my benefit according to the Scudder 403(b) Custodial Agreement if I am a Biweekly Employee, or according to the Duke-Scudder 403(b) Agreement if I am a member of the Faculty and Staff. I agree to the provisions contained in the appropriate Agreement. I acknowledge that I have received a current prospectus for the fund(s) selected for investment.*

**Sign here** \_\_\_\_\_  
**Participant Signature** **Date**

*Important: This Agreement is not effective until the Custodian receives and accepts this Application and establishes the account.*

*Please complete the 403(b) Designation of Beneficiary Form on page 2*



**Participant Name** \_\_\_\_\_  
**SS#** \_\_\_\_\_

Changing Designation of Beneficiary to my 403(b)(7) account.

3. The following person(s) is (are) to receive the balance of my Plan assets upon my death. This designation replaces any previous one I may have filed with the custodian. If I name more than one primary beneficiary and do not indicate percentages, payment will be made equally to the primary beneficiaries who survives me unless I specify otherwise.

Designation of Beneficiary	Name	% Share	Relationship	Date of Birth	Social Security Number
Primary Beneficiary					
Secondary Beneficiary					

With this form you designate the beneficiary who will receive your Plan assets if you die while a balance remains in your account. This designation is not effective until filed with the Custodian (or other such person designated to be the Custodian) prior to your death, and revokes any previous designations. Use this section to tell us how you wish your Plan Assets to be distributed in the event of your death. Provide the name, relationship to you, date of birth and Social Security number of each person you wish to name. Please also indicate the percentage of your Plan assets you would like each person to receive. Percentages must total 100%.

If you indicate a percentage and a primary beneficiary does not survive you, the percentage of that beneficiary's share will be divided equally among the surviving primary beneficiary(ies) unless you specify otherwise. Also, if percentages do not total 100%, any remaining portion will be divided equally among the surviving primary beneficiary(ies) unless you specify otherwise.



**Sign here** \_\_\_\_\_  
**Participant Signature**

\_\_\_\_\_  
**Date**

**Date of Birth** \_\_\_\_\_

**4. Spousal Consent (Complete this section only if you are married and naming someone other than your spouse for more than 50% primary beneficiary)**

I certify that I have read and understand the *Spousal Consent to Waiver* contained in the INSTRUCTIONS, and consent to my spouse's designation of a primary beneficiary other than myself. My consent is limited to the beneficiary(ies) listed above. In addition, recognizing that I also have the right to limit my consent to a specific form of benefits (such as a lump sum distribution or installments over a period of time), by signing below, I relinquish that right and consent to any form of benefits which may be elected under the Plan. I acknowledge that I have read the above elections and understand the effect their exercise will have on me. I also understand that my spouse must execute a new designation if he or she wants to designate another beneficiary.

**Witness**  Plan Representative

*The spouse's signature must be witnessed by a Notary Public or a Plan Representative.* **or**

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary Public

State:

Commission Expires:

Witness

**Spousal Consent to Waiver:** *By signing the attached BENEFICIARY DESIGNATION FORM, I am certifying that the following statements are true:*

- I am the Participant's spouse.
- I understand that if I live in a community property state and I sign the attached BENEFICIARY DESIGNATION FORM, I am voluntarily relinquishing any community property rights I may have to the Participant's vested account balance under the Plan.
- I understand that under the terms of the Plan I am entitled to receive 50% of the Participant's entire vested account balance if the Participant dies before receiving full payment of his/her benefit under the Plan.
- I understand that by consenting to the Participant's beneficiary designation(s) on the attached BENEFICIARY DESIGNATION FORM, the Participant's vested account balance under the Plan will be paid to the designated beneficiary(ies) and not to me.
- I understand that my consent is voluntary and is limited to the beneficiary(ies) designated on the attached BENEFICIARY DESIGNATION FORM. My consent is irrevocable unless the participant revokes this beneficiary designation.