ARKANSAS ENTERPRISES FOR THE DEVELOPMENTALLY DISABLED, INC.
PROFIT SHARING PLAN
ENROLLMENT FORM

I. Employee Information (Please Print)

Last Name	First Name	Middle Initial	Social Security Number
Street Address/Apt. Number	City/State	Zip Code	Date of Birth (Month/Day/Year)
Mailing Address, if different	City/State	Zip Code	Initial Date of Hire (Month/Day/Year)

II. Participant Selection (Choose as applicable)

☐ New Enrollment ☐ Change Participant Contribution Percentage (do not complete section IV)

III. Employee Contribution Percentage

I elect to contribute the following percentage of my compensation each pay period: _____% or $_____

**Annual Limit for 2017 is $18,000. If you are over age 50 you may contribute an additional $6,000.

IV. Investment Selection

I choose to have my account invested as follows:

Initial/Future Contributions
____ % *REREX American Funds EuroPacific Growth Fund R-4*
____ % *LZEMX Lazard Emerging Markets Equity Fund Inst.*
____ % *MHYIX MainStay High Yield Corporate Bond Fund I*
____ % *MFEJX MFS Growth Fund Class R4*
____ % *PMRAX PIMCO Mortgage-Backed Securities Fund A*
____ % *VSGAX Vanguard Small-Cap Growth Index Fund Admiral*
____ % *DDVIX Delaware Value Inst*
____ % *RFCSX Russell Strategic Bond Fund I*
____ % *UBVLX Undiscovered Managers Behavioral Value Inst.*
____ % *VMFXX Vanguard Federal Money Market Fund Inv*
____ % *VWENX Vanguard Wellington Fund Admiral*
100 % TOTAL

****If an investment is not selected, your contribution will automatically be invested in the Vanguard Wellington Fund Admiral Shares fund.**

V. Employee Authorization

I understand that my deferral election is valid only if submitted to Plan Administrator at least ten (10) business days prior to the effective date.

Your Signature	Date

VI. Plan Administrator's Authorization

I, as the Plan Administrator, have reviewed the participant's employment records and hereby authorize participation in the Plan as of the effective date indicated below.

Date of Hire Verified:	Date of Participation
☐ Yes, newly eligible Employee ☐ Rehired Employee who was a former participant ☐ Rehired Employee who was not a participant	____/____/____
Plan Administrator's Representative's Signature	Date