MFS® 403(b) MUTUAL FUND APPLICATION

To establish an account with MFS® Heritage Trust Company℠ as Custodian

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.

You must provide the following information for each person listed on the account: name, date of birth, Social Security number or taxpayer identification number, and residential address (a P.O. Box is not acceptable). We also may ask to see your driver's license or other identifying documents. In the event that MFS Service Center, Inc. (MFSC), on behalf of the fund, is unable to verify the identity of investors, MFSC and the fund reserve the right to take additional steps up to and including closing the account if required by applicable law.

Instructions

Employer 403(b) Plans

- The Employer completes Section 2.
- The Participant completes Sections 1, 4, and 6, as well as Section 5 if applicable.

Salary Reduction 403(b) Plans

- The Employer completes Section 3A. If applicable, the Employer also completes Section 3B.
- The Participant completes Sections 1, 4, 6, and 7. If applicable, the Participant also completes Sections 3B and 5.

Type of Account to be Established

☐ Account for a new participant in an existing plan

☐ Account for a new Salary Reduction 403(b) Plan

1. Participant Information

PARTICIPANT'S FIRST NAME _____ MI _____ LAST NAME _____

☐☐☐-☐☐-☐☐☐☐ SOCIAL SECURITY NUMBER

☐☐/☐☐/☐☐☐☐ DATE OF BIRTH (MM/DD/YYYY)

_____ PHONE NUMBER ☐ MOBILE NUMBER

PARTICIPANT'S MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PARTICIPANT'S RESIDENTIAL ADDRESS (REQUIRED IF DIFFERENT THAN MAILING ADDRESS) _____

CITY _____ STATE _____ ZIP CODE _____

2. Employer Information for Employer 403(b) Plans

This section is applicable to Employer 403(b) Plans only. If the 403(b) is a Salary Reduction Plan, please skip to Section 3.

A new account cannot be established unless the employer has signed an MFS 403(b) Information Sharing Agreement or notified MFS in writing that it is the designated provider under the plan. Please confirm this step has been completed by providing the information and signing below. We need the information in order to verify that we have the agreement or notice on file.

PLAN NAME

EMPLOYER'S NAME

☐☐-☐☐☐☐☐☐☐

TAXPAYER IDENTIFICATION NUMBER

EMPLOYER'S STREET ADDRESS

CITY STATE ZIP CODE

EMPLOYER'S SIGNATURE PRINT NAME

3. Employer Information and Salary Reduction Agreement for Salary Reduction 403(b) Plans

This section is applicable to Salary Reduction 403(b) Plans only. If the 403(b) is an Employer Plan, please complete Section 2. Please complete Section 3A with the Employer information for the Plan. Please provide a signature from an authorized signer of the Employer. If the participant is not using your Employer Salary Reduction Agreement, please also complete Section 3B.

3A. Employer Information

A new account cannot be established unless the employer has signed an MFS 403(b) Information Sharing Agreement or notified MFS in writing that it is the designated provider under the plan. Please confirm this step has been completed by providing the information and signing below. We need the information in order to verify that we have the agreement or notice on file.

PLAN NAME

EMPLOYER'S NAME

☐☐-☐☐☐☐☐☐☐

TAXPAYER IDENTIFICATION NUMBER

EMPLOYER'S STREET ADDRESS

CITY STATE ZIP CODE

EMPLOYER'S SIGNATURE PRINT NAME

3B. Custodial Agreement

If the participant is using the employer's Salary Reduction Agreement, do not complete this section.

NAME OF EMPLOYER

NAME OF EMPLOYEE

The Employer and Employee agree as follows:

1. The Employee authorizes the Employer to reduce the Employee's wages beginning as of the first pay period following the date of this Salary Reduction Agreement in an amount equal to $_____(dollars) or _____% (percent) per payroll period.
2. The Employer agrees to reduce the Employee's wages by such amount as the Employee may designate and further agrees to pay to the Custodian all such amounts withheld within 30 days from the close of each pay period for crediting to the Account of the Employee.
3. The Employee shall have the right to change, or otherwise amend, this Salary Reduction Agreement in accordance with procedures established by the Employer.
4. This Salary Reduction Agreement is considered to be renewed for each subsequent year unless the Employee terminates the Salary Reduction Agreement or provides the Employer with a new Salary Reduction Agreement indicating a different salary reduction amount.

ORGANIZATION NAME

EMPLOYER SIGNATURE | DATE (MM/DD/YYYY)

EMPLOYEE FIRST NAME | MI | LAST NAME

EMPLOYEE SIGNATURE | DATE (MM/DD/YYYY)

EMPLOYEE ADDRESS

CITY | STATE | ZIP CODE

4. Select Your Investments

MFS Family of Funds investment choices: Please Select One: ○ A Shares ○ C Shares

FUND NAME	AMOUNT
	$
	$
	$
	$

TOTAL AMOUNT ENCLOSED $

5. Additional Sources of Funding

- ◯ Transfer of Assets (attach 403(b) Mutual Fund Transfer-In Form)
- ◯ 403(b) Rollover; check enclosed for $_____ (Make check payable to MFS Heritage Trust Co.)

6. Participant Signature and Dealer Information

Must be signed by the account owner and an authorized signer from the broker/dealer firm.

I agree to the provisions contained in the MFS 403(b) Custodial Agreement (Agreement) and to the Custodian establishing an MFS 403(b) Mutual Fund Account (my "Account") for me. I agree that: (1) I have received a copy of the Agreement; (2) I am an Employee of the Employer named in either Section 2 or Section 3 and understand that the Employer will need to confirm my eligibility to request distributions from my Account effective January 1, 2009 (or such later compliance date as may be established by the IRS); (3) I have received a copy of the current prospectus of each MFS mutual fund I have selected; (4) I understand that the Custodian (or its affiliates) and the Employer (or its agents) may share non public personal information with each other in connection with servicing my Account or processing my transactions; (5) I am responsible for computing my maximum annual contribution and for notifying the Custodian of the amount of any excess contributions that I wish to have distributed from my Account; and (6) I have read and I understand the limitations on the duties and liabilities of the Custodian and Distributor under the Agreement. I also certify, under penalties of perjury, that my taxpayer identification number is true, correct, and complete.

PARTICIPANT'S SIGNATURE | DATE (MM/DD/YYYY)

PRINT NAME

This Account becomes effective on the date the Custodian, or its agent, accepts the Application by issuing an investment confirmation to the Employee, provided that the Custodian, or its agent, does not notify the Employee to the contrary within 30 days. We hereby authorize MFSC to act as our agent in connection with transactions under this authorization form and agree to notify MFS Fund Distributors, Inc. of any purchase eligible for a reduced sales charge under a Letter of Intent or Right of Accumulation. We guarantee the investors' signatures and certify that we have verified the identity of the investors.

REGISTERED REPRESENTATIVE'S FIRST NAME | MI | LAST NAME

FIRM NAME | FIRM NUMBER

BRANCH STREET ADDRESS

CITY | STATE | ZIP CODE

BRANCH NUMBER | REGISTERED REPRESENTATIVE'S NUMBER

REGISTERED REPRESENTATIVE'S PHONE NUMBER | REGISTERED REPRESENTATIVE'S EMAIL ADDRESS

BROKERAGE ACCOUNT NUMBER (If applicable) | MATRIX LEVEL

AUTHORIZED SIGNER OF BROKER/DEALER FIRM (REQUIRED) | DATE (MM/DD/YYYY)

If you are aware of additional accounts that may qualify for linking under MFS' ROA policy, please notify us.

7. Beneficiary Information (For Salary Reduction Plans only)

The following designation(s) is (are) subject to the provisions of the Plan. This designation of beneficiary(ies) remains in effect unless and until a new designation of beneficiary form is received in writing by the Custodian.

If you are naming more than one primary or secondary beneficiary, please indicate percentages. Percentages must total 100%. If more than one beneficiary is named and no percentage is indicated, then equal shares will be assigned. If you have additional primary or secondary beneficiaries, attach a separate list and indicate percentages.

Primary Beneficiaries

1. BENEFICIARY'S NAME

RELATIONSHIP: ◯ SPOUSE ◯ OTHER | DATE OF BIRTH/TRUST (MM/DD/YYYY) | SOCIAL SECURITY NUMBER | PERCENTAGE (%)

2. BENEFICIARY'S NAME

RELATIONSHIP: ◯ SPOUSE ◯ OTHER | DATE OF BIRTH/TRUST (MM/DD/YYYY) | SOCIAL SECURITY NUMBER | PERCENTAGE (%)

PRIMARY BENEFICIARY TOTAL (MUST ADD UP TO 100%)

Secondary Beneficiaries (if the primary beneficiary/ies should fail to survive me)

1. BENEFICIARY'S NAME

RELATIONSHIP: ◯ SPOUSE ◯ OTHER | DATE OF BIRTH/TRUST (MM/DD/YYYY) | SOCIAL SECURITY NUMBER | PERCENTAGE (%)

2. BENEFICIARY'S NAME

RELATIONSHIP: ◯ SPOUSE ◯ OTHER | DATE OF BIRTH/TRUST (MM/DD/YYYY) | SOCIAL SECURITY NUMBER | PERCENTAGE (%)

SECONDARY BENEFICIARY TOTAL (MUST ADD UP TO 100%)

If you have any questions about this form, please contact the Retirement Plans Service Department at 1-800-637-1255 any business day.

Mail completed form to:

Regular mail
MFS Service Center, Inc.
P.O. Box 219341
Kansas City, MO 64121-9341

Overnight mail
MFS Service Center, Inc.
Suite 219341
430 W 7th Street
Kansas City, MO 64105-1407

MFS® 403(b) MUTUAL FUND TRANSFER-IN FORM

Use this form to request that a letter of acceptance be sent for a transfer or exchange from your current investment provider. Please include any additional materials required by the current custodian or insurance company.

In order to expedite your request, please include a copy of your most recent statement.

Exchange: Exchange means a transfer of assets to an MFS 403(b) custodial account from a 403(b) of a different investment provider under the same employer plan. **Complete sections 1, 2, 3, 4, and 5.**

Transfer: Transfer means a transfer of assets to an MFS 403(b) custodial account from a 403(b) of a different investment provider under a different employer's plan. **Complete sections 1, 2, 3, 4, 5, and 6.**

Choose One:

- ☐ I have an existing MFS 403(b) mutual fund account under the same employer plan.
  Complete sections 1, 2, 3, 4, and 5.
- ☐ I have an existing MFS 403(b) mutual fund account under a different employer plan.
  Complete sections 1, 2, 3, 4, 5, and 6.
- ☐ I am establishing a new MFS 403(b) account under the same employer plan that covers my 403(b) account at my current investment provider.
  Complete the MFS 403(b) Mutual Fund Application and sections 1, 2, 3, 4, and 5.
- ☐ I am establishing a new MFS 403(b) account under a different employer plan than the one that covers my 403(b) account that exists at my current investment provider.
  Complete the MFS 403(b) Mutual Fund Application and sections 1, 2, 3, 4, 5, and 6.

1. Participant Information (Required)

PARTICIPANT'S FIRST NAME _____ MI _____ LAST NAME _____

☐☐☐-☐☐-☐☐☐☐ SOCIAL SECURITY NUMBER

☐☐/☐☐/☐☐☐☐ DATE OF BIRTH (MM/DD/YYYY)

PHONE NUMBER _____

PARTICIPANT'S MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

REGISTERED REPRESENTATIVE'S NAME _____

REGISTERED REPRESENTATIVE'S PHONE NUMBER _____

2. Agreement Instructions (Required)

Contact your current custodian or insurance company for their requirements before completing this section. Space is provided on the next page for a signature/medallion guarantee, if required.

NAME OF CURRENT INSURANCE COMPANY OR CUSTODIAN

CONTACT NAME

PHONE NUMBER

MAILING ADDRESS

CITY

STATE

ZIP CODE

NAME OF PLAN

403(b) ACCOUNT NUMBER(S)

By this Agreement, I intend to effect a tax-free transfer of my present tax-sheltered annuity contract or 403(b) custodial account to an MFS 403(b) Account. I direct the party named above to surrender or liquidate such _____% or $ _____ of interest in the specified Account(s).

Send assets as follows

☐ **Mail check**

Regular mail
MFS Service Center, Inc.
P.O. Box 219341
Kansas City, MO 64121-9341

Overnight mail
MFS Service Center, Inc.
Suite 219341
430 W 7th Street
Kansas City, MO 64105-1407

Transfer the proceeds by check made payable to:

MFS Heritage Trust Company, Custodian

_____ 403(b)
PLAN NAME

FBO PARTICIPANT NAME

☐ **Wire funds**

State Street Bank and Trust Co.
Boston, MA 02101
ABA #011000028
Credit MFS DDA Number 99034795

3. Authorization Accepted by Participant

I understand that this Agreement is irrevocable and binding. In the event that the undersigned employee receives a check for the proceeds, the check will immediately be endorsed payable to MFS Heritage Trust Company, Custodian, in an integrated transaction under the terms of this Agreement and the MFS 403(b) Mutual Fund Custodial Agreement.

I understand that there is some uncertainty as to the tax status of Exchanges and Transfers of 403(b) custodial accounts because of changes in U.S. Department of the Treasury regulations and that I have independently determined that the Exchange or Transfer should be treated as nontaxable for federal income tax purposes and I am responsible for any and all tax consequences which may result from this Exchange or Transfer.

I agree that neither the Custodian, its agents, the Distributor, or my Employer has made any representations about the validity of this Agreement or about the tax consequences of this transaction.

PARTICIPANT'S SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

Signature guaranteed by:

NAME OF FIRM

SIGNATURE OF AUTHORIZED PERSON

4. Instructions to MFS Heritage Trust Company

Upon receipt of the proceeds from my present 403(b) tax-sheltered annuity contract or custodial account, please purchase the mutual fund(s) indicated below.

- ◯ Open a new account. (Complete and attach the 403(b) Application, upon which you may indicate your investment instructions, leaving the fields below blank.)
- ◯ Invest in my existing MFS 403(b) as follows (also indicate any additional MFS fund choices below). Percentages must total 100%.

FUND NUMBER	PERCENTAGE (%)	FUND NUMBER	PERCENTAGE (%)	FUND NUMBER	PERCENTAGE (%)

5. Authorization by Receiving Employer

For Exchanges within the same plan, the employer plan sponsor must complete this section. If this is a Transfer from one employer's 403(b) plan to a different plan, the employer plan sponsor of the recipient plan must complete this section and the employer of the transferring plan should complete Section 6.

Employer must keep a copy of this form for the plan's records.

Choose One:

- ☐ This transaction is an Exchange between one investment provider and another within the same 403(b) plan, and the undersigned is an authorized signer for the plan named below and the employer plan sponsor.
- ☐ This transaction is a Transfer from another employer's 403(b) plan to the 403(b) plan named below, and the undersigned is an authorized signer for the employer and plan receiving the Transfer named below. If the plan transfer is less than the total 403(b) custodial account or annuity contract ("403(b) contract") at the transferor investment provider, the receiving plan agrees to treat the amount transferred as a continuation of a pro rata portion of the participant's interest in the 403(b) plan to the extent required by regulations under section 403(b) of the Internal Revenue Code ("Code"). The plan also confirms the named employee is a current or former employee of the receiving employer.

In order to ensure that the requested Exchange or Transfer of the participant's 403(b) custodial account, described in Section 2 above, will satisfy the regulations under section 403(b) of the Code ("Regulations"), the undersigned certifies that s/he is an authorized signer for the employer and plan named below and represents and agrees as follows: (1) The plan permits the requested Exchange or Transfer; (2) distribution restrictions imposed under the MFS 403(b) custodial account are not less stringent than those imposed under the transferor 403(b) contract; (3) the accumulated benefit under the receiving contract immediately after the Exchange or Transfer is at least equal to the accumulated benefit under the transferor 403(b) contract immediately prior to the Exchange or Transfer.

PLAN NAME

EMPLOYER'S NAME

☐☐-☐☐☐☐☐☐☐☐☐
TAXPAYER IDENTIFICATION NUMBER

PHONE NUMBER

EMPLOYER'S MAILING ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER'S SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

TITLE

NAME OF THIRD PARTY AUTHORIZED TO PROVIDE INFORMATION FOR EMPLOYER (IF ANY)

THIRD PARTY ADMINISTRATOR'S MAILING ADDRESS

CITY | STATE | ZIP CODE

THIRD PARTY ADMINISTRATOR'S PHONE NUMBER

6. Authorization by Transferring Employer

For Transfer from one employer's 403(b) to another's. Do not complete for Exchanges within the same plan.

Employer must keep a copy of this form for the plan's records.

This transaction is a Transfer from the 403(b) plan named below (Transferor Plan) to another employer's 403(b) plan as named in Section 5 above, and the Transferor Plan allows this transfer.

NAME OF TRANSFEROR PLAN

EMPLOYER'S NAME

☐☐-☐☐☐☐☐☐☐☐☐

TAXPAYER IDENTIFICATION NUMBER

PHONE NUMBER

EMPLOYER'S ADDRESS

CITY

STATE

ZIP CODE

EMPLOYER'S SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

TITLE

7. Acceptance by New Custodian

To be completed by MFS Heritage Trust Company

MFS Heritage Trust Co. accepts its appointment as Custodian of the above Employee's 403(b) Account and requests that the liquidation and transfer of assets directed above be sent to the address shown on this agreement.

AUTHORIZED MFS SIGNATURE ON BEHALF OF MFS HERITAGE TRUST COMPANY

DATE (MM/DD/YYYY)

If you have any questions about this form, please contact the Retirement Plans Service Department at 1-800-637-1255 any business day.

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P.O. Box 219341
Kansas City, MO 64121-9341

Overnight mail
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430 W 7th Street
Kansas City, MO 64105-1407