Jacobsen, et al., v. Long Island Community Hospital, et al. ERISA Settlement

Former Participant Rollover Form

If you were a participant in the Brookhaven Memorial Hospital Medical Center DBA Long Island Community Hospital Retirement Savings Plan (the "Plan") at any time between January 18, 2018 through September 24, 2026 (the "Class Period") and were invested in any of the following investments at any time during the Class Period: Janus Henderson Enterprise Fund (T), MFS New Discovery Value Fund (R3), John Hancock Disciplined Value Mid Cap Fund (I), American EuroPacific Growth Fund (R4), Dreyfus Strategic Value Fund (I), or the Prudential Guaranteed Income Fund, or are a Beneficiary or Alternate Payee of such a participant, and you no longer have, or expect that you will no longer have, an account balance in the Plan greater than $0.00 at the time settlement payments are calculated, and would like your amount payable to be paid to a qualified retirement account as a rollover, you must complete the form below and mail it to the Settlement Administrator at the below address, or submit it online at www.licherisasettlement.com , no later than December 25, 2026:

Jacobsen, et al. v. Long Island Community Hospital, et al.
c/o RG/2 Claims Administration LLC
P.O. Box 59479
Philadelphia, PA 19102-9479

"Beneficiary" or "Alternate Payee" means, for the purposes of this Former Participant Rollover Form, a Beneficiary or Alternate Payee of a participant in the Plan who maintained an account balance greater than $0.00 in the Plan during the Class Period.

Please note: Your rollover election will apply only if you do not have an Active Account in the Plan (an account balance greater than $0.00) at the time settlement payments are calculated and are entitled to a distribution of $10.00 or more. If you have an Active Account at that time, your settlement payment will be deposited into your Plan account regardless of any election made on this form. Former Participants entitled to a distribution of $9.99 or less will not receive a distribution, pursuant to the Parties' Plan of Allocation.

PARTICIPANT INFORMATION

Mail ID Number (as found on the notice you received): _____

First Name: _____ M.I.: _____ Last Name: _____

Mailing Address: _____

Participant's Social Security Number: _____

Email Address: _____

Phone: _____

Participant's Date of Birth: _____

PAYMENT ELECTION

_____I WANT A CHECK MADE PAYABLE TO ME AND MAILED TO ME. If you choose this option, the Settlement Administrator will withhold applicable federal and state taxes from your total payment as required by law. The Settlement Administrator will mail your check to the Name and Address listed above.

_____I WANT A CHECK MADE PAYABLE TO MY RETIREMENT ACCOUNT AS A ROLLOVER

Rollover Institution: _____

Rollover Account Name: _____

Rollover Account Number: _____

Mailing Address: _____

DISTRIBUTION NOTE: There is no promise or assurance that these funds are eligible for rollover or tax-preferred treatment. The decision to seek rollover treatment is yours alone. Any questions about taxation or rollover treatment must be directed to your tax advisor or accountant. No one associated with this case can provide you with assistance or advice of any kind in this regard or answer any tax questions.

REQUIRED CERTIFICATION REGARDING QUALIFIED DOMESTIC RELATIONS ORDER ("QDRO"):

I hereby certify and represent under penalty of perjury that no portion of the payment to be received hereunder is subject to a QDRO, or, that a true, accurate, and current copy of any applicable QDRO is attached hereto along with the name and address of any payee other than the Class Member. Payment will be made in accordance with any QDRO supplied.

Signature (Required): _____

Date Signed (Required): _____

DECEASED CLASS MEMBERS

Deceased Class Members are not eligible for rollover treatment. A Beneficiary of a deceased person who was a participant in the Plan at any time during the Class Period, including executors, heirs, assigns, estates, personal representatives, or successors-in interest, must provide the following information with this Former Participant Rollover Form to the Jacobsen, et al., v. Long Island Community Hospital, et al. ERISA Settlement Administrator:

- Death certificate and evidence that such person is authorized to receive distribution of the deceased Class Member's settlement payment, and the name and, if applicable, the percentage entitlement of each person entitled to receive distribution;
- Social Security Number of each person entitled to receive payment;
- Current mailing address of each person entitled to receive payment; and
- Person(s) to whom check(s) should be made payable, and percentage amount(s) of check(s).

BENEFICIARY INFORMATION
(only provide if this person is entitled to receive payment as the participant's Beneficiary)

First Name: _____ M.I.: _____ Last Name: _____

Mailing Address: _____

Beneficiary's Social Security Number: _____

Email Address: _____

Phone: _____

Beneficiary's Date of Birth: _____