



■ Information about the participant				
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Important: This section must be completed before an account can	be established. Please type or	print clearly.		
SSN of participant Date of birth of pa	articipant (mm/dd/yyyy)	Country of citizens	hip	
	, , , , , , , , , , , , , , , , , , , ,	,	•	
First name of participant (print)	MI Last			
This name of participant (print)	IVII Last			
Residence address (physical address required — no P.O. boxes)	City		State	ZIP
Mailing address (if different from residence address)	City		State	ZIP
		()		
Email address*		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
		,		
-	not married.			
*Your privacy is important to us. For information on our privacy policies, vis	it www.capitaigroup.com.			
Information about the employer				
2				
_				
Name of organization Plan ID		EIN		
		()	Ex	ĸt.
Name of employer contact		Daytime phone		
Address	City		State	ZIP
Investment instructions				
For a quick guide to fund names, numbers, minimums and share cl	ass restrictions, go to www.ca j	oitalgroup.com/fundguid	le. Only Cla	ss A share
investments are available for this plan type.				
Note: The minimum initial and subsequent investment is \$25 per fu			_	
selections identi ed below. To make changes to your fund sel		Illocations in the future,	notify your	employer.
The percentage speci ed must equal the fund minimum of \$	25 per fund.			
Fund name or number	Percentage			
	0/			
	%			
	%			
	%			
	%			
	0/			
	%			
Total contribution	%			
Note: The \$10 setup fee will be deducted from your account.				







Beneficiary designation

We encourage you to consult a professional regarding the tax-law and estate planning implications of your beneficiary designation. All stated percentages must be whole percentages (e.g., 33%, not 33.3%). If the percentages do not add up to 100%, each beneficiary's share will be based proportionately on the stated percentages. When percentages are not indicated, the beneficiaries' shares will be divided equally.

Notes: • Your spouse may need to sign in Section 5. If you wish to name more than one trust or entity, customize your designation or need more space, attach a separate page. Include the name, address, relationship, date of birth or trust, SSN/TIN and percentage for each beneficiary.

A. Primary Beneficiary(ies): If any designated Primary Beneficiary(ies) dies before I do, that beneficiary's share will be divided proportionately

- If you name a trust as beneficiary, provide the full legal name of the trust. Example: "The Davis Family Trust."
- among the surviving Primary Beneficiaries unless otherwise indicated. If no Primary Beneficiaries survive me, assets will be paid to the named Contingent Beneficiaries, if any. First name (print) MΙ Last name Suf x OR Name of trust or other entity (print) ZIP City State Address Child of owner Other person Trust Other entity Date of birth or trust (mm/dd/yyyy) SSN/TIN Whole % only Spouse' 2. First name (print) MΙ Last name Suf x Address City State ZIP Other person Date of birth (mm/dd/yyyy) SSN Whole % only Spouse' Child of owner First name (print) ΜI Last name Suf x City State ZIP Address Date of birth (mm/dd/yyyy) Other person SSN Whole % only Spouse' Child of owner MI First name (print) Last name Suf x City ZIP Address State

SSN

Date of birth (mm/dd/yyyy)

Other person

Whole % only

^{*} By naming my spouse as a bene ciary, I elect to treat such spouse as a bene ciary while we are married. Effective immediately upon the divorce, annulment or other lawful dissolution of my marriage, the designation shall be null and void, unless after the dissolution of my marriage I af rmatively elect to name my former spouse as my non-spouse bene ciary.





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Beneficiary designation

(continued)

Important: Section 4-A must be completed prior to completing Section 4-B.

FIISTHAIL	ne (print)		MI	Last name		<u> </u>	Suf x
Name of	trust or other entity (print)						
Address				City		tate Z	ZIP
Spouse*	Child of owner Other person	on Trust Other entity	Date of b	irth or trust (mm/dd/yyyy)	SSN/TIN	Wh	ole %
First nan	ne (print)		MI	Last name		<u> </u>	Suf x
Address				City		tate Z	ZIP
Spouse*	Child of owner Other pers	on Date of birth (mm/	dd/yyyy)	SSN		Wh	ole %
First nan	ne (print)		MI	Last name		<u></u>	Suf x
Address				City	<u></u> <u></u>	tate Z	ZIP
Spouse*	Child of owner Other pers	Date of birth (mm/	dd/yyyy)	SSN		Wh	ole %
First nan	ne (print)		MI	Last name		<u>_</u>	Suf x
Address				City	s	tate Z	ZIP
 Spouse*	Child of owner Other pers	on Date of birth (mm/	dd/yyyy)	SSN		Wh	ole %

^{*} By naming my spouse as a bene ciary, I elect to treat such spouse as a bene ciary while we are married. Effective immediately upon the divorce, annulment or other lawful dissolution of my marriage, the designation shall be null and void, unless after the dissolution of my marriage I af rmatively elect to name my former spouse as my non-spouse bene ciary.

Spousal consent

Consult you nancial professional and/or employer about the need for spousal consent.

I am the spouse of the participant named in Section 1. I irrevocably consent to the designation made by my spouse to have any death bene ts paid to the named bene ciary(ies) speci ed in Section 4. I understand that the effect of such designation is to cause my spouse's death bene t to be paid to a bene ciary other than me, that such bene ciary designation is not valid unless I consent to it and that my consent is irrevocable unless my spouse revokes the bene ciary designation.

	X		1	
Name of spouse of participant (print)	Signature of spouse of participant	Date	(mm/dd/yyyy)	
This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.				

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Signature

By signing below, I acknowledge that I agree to the bene ciary designation default or I have designated the bene ciary(ies) in Section 4 or on the attached page. I understand that I and all shareholders at my address will receive one copy of fund documents (such as annual reports and proxy statements) unless I opt out by calling (800) 421-4225.

	X		1 1
Name of participant (print)	Signature of participant	Date	(mm/dd/yyyy)

This document may not be signed using Adobe Acrobat Reader's "fill and sign" feature.

Please mail or fax this form to the appropriate service center.

(If you live outside the U.S., mail the form to the Indiana Service Center.)



Indiana Service Center

American Funds Service Company P.O. Box 6164 Indianapolis, IN 46206-6164

Overnight mail address 12711 N. Meridian St. Carmel, IN 46032-9181 **Fax** (888) 421-4371

Virginia Service Center

American Funds Service Company P.O. Box 2560 Norfolk, VA 23501-2560

Overnight mail address 5300 Robin Hood Rd. Norfolk, VA 23513-2430

Fax (888) 421-4371

If you have questions or require more information, contact your financial professional or call American Funds Service Company at (800) 421-4225.