StateFarm®

529 Savings Plan

Payroll Direct Deposit

Return this Form to:

State Farm 529
P.O. Box 86529
Lincoln, NE 68501-6529

Overnight Mail:

State Farm 529
1248 O Street, Suite 200
Lincoln, NE 68508

If you have questions, please call us at **800.321.7520,** Monday–Friday, 7 a.m. to 7 p.m. (CT).

1. I Would Like to Use this Form to:

☐ **Start Payroll Direct Deposit**
☐ **Change the Contribution Amount**

Employee Steps:

1. Complete all four sections below.
2. Provide your State Farm 529 Savings Plan Account number(s) in Section 4. If you do not have a State Farm 529 Savings Plan Account, please complete an Enrollment Form and mail both forms to State Farm 529 Savings Plan.

Employer Steps:

1. Enter this withholding into your payroll system.
2. Fax this form to the State Farm 529 Savings Plan at 402.323.1053. Keep a copy of this form for your files.
3. Begin withholding as directed in Section 4.
4. The State Farm 529 Savings Plan will contact you regarding contribution and remittance methods.

2. Account Owner Information

Name (First, M.I., Last): _____

Street Address (no P.O. Boxes): _____

City, State, Zip: _____

Mobile Phone Number: _____

Secondary Phone Number: _____

Email Address: _____

Contributor Name (if different than the Plan Account Owner): _____

3. Employer Information

Company or Agency Name: _____

Street Address: _____

City, State, Zip: _____

Payroll Contact Name: _____

Payroll Contact Phone Number: _____

Payroll Contact Email Address: _____

Payroll Contact Fax Number: _____

4. Payroll Direct Deposit Information

Amount of Payroll Direct Deposit (per pay period): $ _____

Requested Start Date (check with your employer): _____

I request that the above deduction be deposited into the following State Farm 529 Savings Plan Account(s) **(must total 100%, only whole percentages allowed):**

Beneficiary Name	Plan Account Number	Percentage
		%
		%
		%
		%

5. Authorization

I hereby authorize the ongoing payroll direct deposit as set forth above and acknowledge that this deduction will continue until I notify my employer in writing to change or stop the deduction.

Signature and Date Required

X _____

Signature of Account Owner, Custodian (UGMA/UTMA Accounts), or Trustee — Date

_____

Print Name Here

_____

Title (if other than an individual)

Program Manager

Distributor

Nebraska Educational Savings Plan Trust, Issuer. Nebraska State Treasurer, Trustee. Nebraska Investment Council, Investment Oversight. Union Bank and Trust Company, Program Manager. Northern Trust Securities, Inc. Distributor, Member FINRA, SIPC. State Farm, Selling Dealer.