



INITIAL ENROLLMENT FORM

Lemek, LLC dba Panera Bread 401(k) Profit Sharing Plan

1 Information (about you)

First Name (print)			MI	Last Name		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number			Date of Birth (mm-dd-yyyy)		Date of Hire (mm-dd-yyyy)	

Mailing Address		City	State	Zip
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone Number (mobile # preferred)		Email Address		
<input type="text"/>		<input type="text"/>		

Check here to sign up for Electronic Statements*

*If electing Electronic Statements, you may switch to paper statements at any time by updating your personal setting on the participant website

2 Contribution Election

I understand that my Salary Deferral Contribution may not exceed \$23,000 for the calendar year 2024, plus if I am age 50 by 12/31/2024 I am eligible to contribute an additional \$7,500.

- I elect to contribute ____% of my pay or \$_____ as a Salary Deferral Contribution (pre-tax) each pay period.
- I do NOT want to participate. I understand that I may reconsider my decision at a future date.

3 Investment Allocation

Enter the percentage you want to invest in each option below, making certain that the total is equal to 100%. If no elections are made, any deposits made to your account will be invested in the Default Investment selected by the Plan Sponsor.

Stable Value / Money Market

_____% MetLife Stable Value 25053 CIO (MACXS)

Fixed Income

_____% AB Global Bond Z (ANAZX)

_____% Federated Hermes Ttl Return Bd R6 (FTRLX)

_____% Janus Henderson Multi-Sector Income N (JMTNX)

_____% JPMorgan Government Bond I (HLGAX)

Balanced

_____% Dodge & Cox Balanced I (DODBX)

Target Date Funds

_____% T. Rowe Price Retirement 2010 (TRRAX)

_____% T. Rowe Price Retirement 2015 (TRRGX)

_____% T. Rowe Price Retirement 2020 (TRRBX)

_____% T. Rowe Price Retirement 2025 (TRRHX)

_____% T. Rowe Price Retirement 2030 (TRRCX)

_____% T. Rowe Price Retirement 2035 (TRRIX)

_____% T. Rowe Price Retirement 2040 (TRRDY)

_____% T. Rowe Price Retirement 2045 (TRRKX)

_____% T. Rowe Price Retirement 2050 (TRRMX)

Domestic Equity

_____% Columbia Small Cap Value I Inst3 (CSVYX)

_____% Dodge & Cox Stock I (DODGX)

_____ % Janus Henderson Enterprise N (JDMNX)
 _____ % JPMorgan Large Cap Growth R6 (JLGMX)
 _____ % T. Rowe Price Integ. US SmallCap Gr Eq (PRDSX)
 _____ % T. Rowe Price Mid-Cap Value I (TRMIX)
 _____ % Vanguard 500 Index Adm (VFIAX)
 _____ % Vanguard Mid Cap Index Adm (VIMAX)
 _____ % Vanguard Small Cap Index Adm (VSMAX)

International / Global Equity

_____ % American Funds New World R6 (RNWGX)

_____ % Baron International Growth R6 (BIGUX)
 _____ % Fidelity Overseas (FOSFX)
 _____ % Pioneer Global Sustainable Equity K (PGEKX)
 _____ % Putnam International Value R6 (PIGWX)

Alternatives

_____ % Fidelity Real Estate Investment (FRESX)

_____ % **TOTAL = 100%**

4 Required Signature

By signing below, I acknowledge that I have received and read the Summary Plan Description and the annual investment information notice. I understand that the value of investments may fluctuate over time and that there are risks associated with each investment option. I understand that the investment allocation instructions will remain in effect until I replace them by making changes through the use of the retirement plan website or voice-response system. Further, I understand that the contribution amounts will remain unchanged until I contact my Human Resources Department.

_____ **X** _____
 Participant Name (print) Participant Signature Date

Return completed form to your Human Resources Department.

Plan Sponsor Authorization

_____ **X** _____
 Authorized Plan Signer Name (print) Authorized Plan Signer Signature Date



BENEFICIARY DESIGNATION FORM

Lemek, LLC dba Panera Bread 401(k) Profit Sharing Plan

1 Information (about you)

First Name (print) _____ MI _____ Last Name _____

- -

Social Security Number _____ Date of Birth (mm-dd-yyyy) _____

Marital Status: Married Single

If you are married you must name your spouse as the sole primary beneficiary unless your spouse consents in writing to you designating another Primary beneficiary. If you are not married at the time you designate your beneficiaries and subsequently marry, 100% of your vested account balance will be paid at the time of death to your surviving spouse unless your spouse consents in writing (see Section 3: Spousal Consent).

2 Beneficiary Designation

I revoke all previous designations and direct that any benefit proceeds be distributed upon my death to the designated beneficiary(ies) below. In the event that no Primary or Contingent Beneficiaries survive me, any benefit payments will be distributed according to the terms of the plan document.

X _____ Initial here if you would like to designate additional beneficiaries that do not fit within the spaces provided here. Please write the information on a separate sheet of paper. Sign and date the page, and staple it to this form.

A) PRIMARY BENEFICIARY(IES) Beneficiaries will share equally if percentages are not provided.

1. _____ %

Name (First, Middle Initial, Last) _____ Relationship _____

- -

Social Security Number _____ Date of Birth (mm-dd-yyyy) _____

_____ Mailing Address _____ City _____ State _____ Zip _____

_____ Phone Number _____ Email Address _____

2. _____ %

Name (First, Middle Initial, Last) _____ Relationship _____

- -

Social Security Number _____ Date of Birth (mm-dd-yyyy) _____

_____ Mailing Address _____ City _____ State _____ Zip _____

_____ Phone Number _____ Email Address _____

PRIMARY BENEFICIARY(IES) TOTAL = 100%

B) CONTINGENT BENEFICIARY(IES) (complete ONLY if naming a Primary Beneficiary above)

If no Primary Beneficiary survives the Participant, benefits will be paid to the Contingent Beneficiaries below. Beneficiaries will share equally if percentages are not provided.

1. _____ %

Name (First, Middle Initial, Last) _____ Relationship _____

- -

Social Security Number _____ Date of Birth (mm-dd-yyyy) _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

2. _____ %

Name (First, Middle Initial, Last) _____ Relationship _____

- -

Social Security Number _____ Date of Birth (mm-dd-yyyy) _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

CONTINGENT BENEFICIARY(IES) TOTAL = 100%

3 Spousal Consent (complete only if married and your sole primary beneficiary is not your spouse)

I am the spouse of the participant whose name appears on this form. I irrevocably consent to the designation made by my spouse to have any death benefits paid to the named beneficiary(ies) in Section 2: Beneficiary Designation. I understand that by consenting to this designation, I am foregoing both present and future rights to these benefits if my spouse dies. I further understand my consent is irrevocable unless my spouse revokes the Primary Beneficiary designation on this form. By my signature below, I approve the designation made. I acknowledge that I had the opportunity to consult my attorney or other professional concerning this waiver, if I had so desired.

_____ _____

Spouse Full Name (print) Spouse Signature Date

Either a plan representative appointed by the Employer or a notary public must witness the signature of the spouse.

_____ _____

Plan Representative Name (print) Plan Representative Signature Date

Sworn to and subscribed before me, this _____ day of _____, 20_____.

In the County of _____, State of _____.

_____ _____

Notary Public Name (print) Notary Public Signature Date Commission Expires

4 Required Signature

Subject to the spousal consent requirements, I understand that I may revoke or change this designation at any time by filing a new designation of beneficiary with the Employer, and that by doing so, I revoke all prior designations.

_____ X _____
Participant Name (print) Participant Signature Date

Return completed form to your Human Resources Department.

Plan Sponsor Authorization

_____ X _____
Authorized Plan Signer Name (print) Authorized Plan Signer Signature Date