Deferred Compensation Plan Authorized Cooperative/Employer Representative Form

Homestead Funds

Cooperative/Employer: Use this form to designate which individuals are authorized to act on your behalf.

Homestead Funds will act on transaction and maintenance instructions only when they are signed for by an authorized cooperative/employer representative named on this form. (The one exception is for the phone exchange option that many cooperatives have elected. The phone exchange option allows both participants and authorized cooperative/employer representatives to exchange shares between identically registered accounts over the phone.) If multiple representatives are listed on this form, only one signature is required to act.

If you have a question about the form, call us at **800.258.3030.** For complete information about Homestead Funds and services, see the prospectus, which is available at **homesteadfunds.com** or by calling the above toll-free number.

Sending forms to NRECA will delay processing. Return your completed form to:

Regular Mail
Homestead Funds
c/o BFDS
P.O. Box 219486
Kansas City, MO 64121-9486

Overnight Mail
Homestead Funds
c/o BFDS
330 W. 9th Street, 1st Floor
Kansas City, MO 64105-1514
Attn: Shareholder Services

1. Account Registration

We must receive the original signed document for signature verification. Keep a copy for your records.

This section needs to be completed with the Cooperative/Employer's information only.

Cooperative/Employer's Name

Tax Identification Number

Cooperative/Employer's Residential Street Address

City | State | Zip Code

2. Designating Authorized Cooperative/Employer Representatives

By signing this form, I certify that:

- I have received, read and agree to the terms of the prospectus for the funds in which the cooperative/employer is investing. I have the authority and legal capacity to purchase mutual fund shares on behalf of my cooperative/employer and am of legal age in my state and believe such investment is suitable for my organization.
- The cooperative/employer has received, read and completed an applicable deferred compensation program plan document and election form, which set forth the terms and conditions of the cooperative/employer's participation in the deferred compensation program.
- I understand that it is the cooperative/employer's responsibility to determine that all requests are in compliance with the plan's provisions.
- I understand that it is the cooperative/employer's responsibility to keep the list of authorized cooperative/employer representatives current.
- I understand that I may not authorize requests on accounts for which I am the beneficiary (except phone exchanges).
- The cooperative/employer authorizes Homestead Funds, BFDS, their agents and affiliates to act on any instructions believed to be genuine for any service authorized by the cooperative/employer on this form and agrees that they will not be liable for any resulting loss or expense to the cooperative/employer resulting from such reliance.

Deferred Compensation Plan Authorized Cooperative/Employer Representative Form

Homestead Funds

2. Designating Authorized Cooperative/Employer Representatives (continued)

- The cooperative/employer authorizes Homestead Funds to provide account information to NRECA if electing Administrative Services.
- The tax identification number shown in Section 1 of this form is correct.

Signature of Authorized Cooperative/Employer Representative

Title

Print Name

Date (mm/dd/yyyy) / /

Signature of Authorized Cooperative/Employer Representative

Title

Print Name

Date (mm/dd/yyyy) / /

Signature of Authorized Cooperative/Employer Representative

Title

Print Name

Date (mm/dd/yyyy) / /

The Authorized Cooperative/Employer Representatives named on this form will replace any Authorized Cooperative/ Employer Representatives currently on file.

Be sure the Cooperative Authority signs this form in **Section 3.** We cannot act on these instructions without the Cooperative/Employer Authority's notarized signature.

3. Cooperative/Employer Authority Signature

I authorize the individual's named in **Section 2** to act on behalf of the cooperative/employer for the Deferred Compensation Plan accounts.

Signature of General Manager, CEO or other Cooperative/Employer Authority

Title

Print Name

Date (mm/dd/yyyy) / /

4. Notary Acknowledgement

The signature of the cooperative/employer authority in **Section 3** of this form must be notarized.

State of _____

County of _____

On this _____ day of_____, 20 _____, before me personally appeared

_____ , to me personally known to be the individual described herein and who executed the foregoing instrument, and acknowledged that he executed the same.

_____

Notary Public

My commission expires: _____

Notary: Affix stamp here