



EMPLOYEE STOCK PURCHASE PLAN SUBSCRIPTION AGREEMENT AND CHANGE FORM

This form is used by employees to authorize payroll deductions and/or make changes to their participation in eFund's Employee Stock Purchase Plan. Please **print or type** the information to complete Section (A) & (B) along with any additional section(s) based on the instructions below. **A hard copy of this form must be signed by the employee upon completion and received by the Compensation Department in Scottsdale by the 15th of the month prior to the Purchase Period. The form can be addressed to Compensation Department – Scottsdale by internal mail or to the Compensation Department, eFunds Corporation, Gainey Center II, Suite 300, 8501 North Scottsdale Road, Scottsdale, AZ, 85253.**

- ENROLLMENT IN STOCK PURCHASE PLAN
- CHANGE PERCENTAGE DEDUCTION
- CHANGE ISSUANCE NAME(S)
- CHANGE DEATH BENEFICIARY (Must also contact E*TRADE with updated information)

(A) Personal Data:

Last Name, First Name, Middle Initial:		Employee ID:	Location:
Social Security Number: / /	Effective Date:	Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	

(B) Percentage of gross pay to be deducted: I hereby authorize the payroll deductions in the amount indicated below from my current compensation.

<input type="checkbox"/> 2% <input type="checkbox"/> 3% <input type="checkbox"/> 4% <input type="checkbox"/> 5% <input type="checkbox"/> 6% <input type="checkbox"/> 7% <input type="checkbox"/> 8% <input type="checkbox"/> 9% <input type="checkbox"/> 10%

(C) Death Beneficiary: In the event of death, the following are designated as beneficiary(ies).

1. First Name, Middle Initial, Last Name:		Social Security Number: / /		Relationship to Employee:	
Street Address:	City:	State:	Zip: -	% To Receive: %	
2. First Name, Middle Initial, Last Name:		Social Security Number: / /		Relationship to Employee:	
Street Address:	City:	State:	Zip: -	% To Receive: %	

I UNDERSTAND THAT THIS SUBSCRIPTION AGREEMENT SHALL REMAIN IN EFFECT THROUGHOUT SUCCESSIVE PURCHASE PERIODS UNLESS TERMINATED BY ME.

Signature of Employee

Date: _____

Spouse's Signature (If beneficiary other than spouse)