

KENTUCKY PUBLIC EMPLOYEES' DEFERRED COMPENSATION AUTHORITY

LIMITED POWER OF ATTORNEY  
(Durable Power of Attorney)

**NOTICE: THIS IS AN IMPORTANT LEGAL DOCUMENT WHICH CREATES LEGAL RIGHTS AND DUTIES. YOU SHOULD CONSULT YOUR LEGAL ADVISOR BEFORE SIGNING.**

NAME: \_\_\_\_\_ (please print)

SOCIAL SECURITY #: \_\_\_\_\_ (last 4 digits)

This Limited Power of Attorney ("LPOA") applies to my account balance held under either/both of the Kentucky Employees' 457 Deferred Compensation Plan and the Kentucky Public Employees' 401(k) Deferred Compensation Plan (the "Plans"), including any deemed IRA account held for my benefit.

Effective as of the date accepted, I authorize – (NAME ONLY ONE PERSON FOR AGENT AND ONE OTHER PERSON FOR SUCCESSOR AGENT)

AGENT

SUCCESSOR AGENT (upon death, resignation, incapacity or declination of my Agent)

\_\_\_\_\_  
(Agent's Name) (Please print)

\_\_\_\_\_  
(Successor Agent's Name) (Please print)

\_\_\_\_\_  
(Agent's Address/Email)

\_\_\_\_\_  
(Successor Agent's Address/Email)

\_\_\_\_\_  
(Agent's Phone Number)

\_\_\_\_\_  
(Successor Agent's Phone Number)

\_\_\_\_\_  
(Agent's Social Security Number)

\_\_\_\_\_  
(Successor Agent's Social Security Number)

("Agent")

("Successor Agent")

-- as my true and lawful agent with authority solely with respect to the matters specifically noted below (and no other actions) in this LPOA in connection with my account(s) held for my benefit under the Plan(s) (the "Account").

**This page requires your initials at the bottom.**

1. I hereby authorize my Agent to take all the following specific actions (and no other actions):
  - A. to make investment exchanges, investment decisions, and direct my Plan investments
  - B. to request withdrawal of my Account upon my termination of employment, retirement, hardship, or unforeseeable emergency (including withholding elections and form and timing of distributions) for distribution, payment, or withdrawal payable to me
  - C. to amend the form, amount, and timing of payment of withdrawals paid to me, including changes to periodic distributions
  - D. to borrow from my Account
  - E. to request duplicate participant statements
  - F. to authorize payment of Plan and Authority fees
  - G. to request transfer of my Account to another eligible retirement plan
  - H. to access the Plan website for making transactions
  - I. to request rollovers/transfers into my Account
  - J. to change my mailing address for receipt of notices, forms, and statements from the Plan
  - K. to change my beneficiary
  - L. to access information about my Account and to change my password for on-line access

2. I represent that I am of full legal age under applicable law, I am competent to execute this LPOA, and I am a participant in the Plan(s).

3. This LPOA shall become effective on the date accepted by the Authority or its agent(s). This LPOA shall remain in effect until the Authority receives my written notice of revocation or death.

4. I understand that my divorce or legal separation does not operate to revoke this LPOA, and it is my responsibility to notify the Authority in writing of any changes with respect to this LPOA.

5. This LPOA shall bind my heirs, executors, administrators, successors, and assigns.

6. The Authority may reject and return this LPOA to me at any time. Acceptance by the Authority does not obligate the Authority to deal with my Agent, and the Authority, in its discretion, may decide to deal solely with me and not my Agent.

7. I hereby ratify and affirm any and all transactions made heretofore or hereafter by my Agent or Successor Agent with respect to my Account, and I shall be legally bound by such transactions.

8. I indemnify and hold harmless the Authority, its officers, employees, and trustees, Plans and Trusts from and against all claims, actions, costs, and liabilities arising out of or relating to their reliance on this LPOA. My indemnification is continuing and shall not be affected by any revocation of this LPOA.

\_\_\_\_\_ Initials

THIS LIMITED POWER OF ATTORNEY SHALL NOT BE TERMINATED BY MY SUBSEQUENT INCAPACITY (DURABLE POA).

By signing below, I agree that I have read and understood this LPOA and agree to its terms and conditions, and I shall be bound by the terms and conditions of the Plans and Trusts and understand that copies of such documents are available to me. This LPOA will be administered in compliance with applicable Plan and Trust provisions. I am signing this LPOA free of any duress or coercion, and there is no pending or contemplated petition to determine my incapacity or appoint a guardian for me. Any other Powers of Attorney signed by me shall have no legal effect on the Authority or my Account. My Agent may not amend or revoke this LPOA.

The Authority does not give legal advice. If there is anything about this LPOA, which you do not understand, you should consult your attorney before signing this LPOA.

\_\_\_\_\_  
Name (Please Print)    Signature    Date

[SIGNED IN THE PRESENCE OF TWO DISINTERESTED WITNESSES]

\_\_\_\_\_  
Signature    Name (Please Print)

\_\_\_\_\_  
Signature    Name (Please Print)

NOTARY:

STATE OF \_\_\_\_\_ )  
   )  
COUNTY OF \_\_\_\_\_ )

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, by \_\_\_\_\_.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public  
Notary I.D. #: \_\_\_\_\_