

WORKDAY, INC.

Voluntary Disability Plan for California Workmates

Request to Opt-Out

By signing and submitting this form to Workday People & Purpose, you are confirming that:

- I elect to participate in the State Disability Insurance Plan effective the first day of the next calendar quarter following receipt of this request by Workday.
- I understand that by doing so I waive my rights to any benefit improvements or other advantages offered by the Workday Voluntary Disability Plan.
- I understand deductions from my paycheck will be as required by the State.
- I understand that I may not change my election again until the start of the calendar quarter following notification to Workday that I wish to participate in the Workday Voluntary Plan.

Workmate Name:

Workday ID#:

Signature:

Date: