

Stock Purchase Plan Authorization



Enrollment Information - I/we wish to enroll by making an initial investment and am/are residents of a qualifying state (Arizona, Florida, Minnesota, North Dakota, South Dakota or Texas). Enclosed is a check payable to Otter Tail Corporation DR Plan. (Minimum initial investment is \$250 - maximum \$10,000). *Please return this form with your check directly to the Shareholder Services at the address listed.*

Shareholder Services
215 South Cascade
PO Box 496
Fergus Falls, MN 56538-0496

Toll free: (800) 664-1259
Local: (218) 739-8479
Email: sharesvc@ottertail.com
Website: www.ottertail.com

Account Types – Select One- PLEASE PRINT

Individual Ownership

Your Name _____

Joint Ownership (with Right of Survivorship) Joint accounts will be registered as Joint Tenants with Right of Survivorship (JT TEN), and not as tenants in common, unless otherwise indicated or restricted by applicable state law.

Joint Owner (if any) _____

Custodial - A minor is the beneficial owner of the account with an adult custodian managing the account until the minor becomes of age, as specified in the Uniform Gift/Transfers to Minors Act in the minor's state of residence. Please provide the minor's Social Security Number.

Custodian's Name _____
First Middle Initial Last

Minor's Name _____
First Middle Initial Last

Minor's Social Security Number (required) _____

Trust Account - Account is established in accordance with the provisions of a trust agreement. Please provide a copy of the first and last pages of the executed trust agreement, or a Certificate of Trust, with this Authorization form.

Trustee(s) Name(s) _____

Date of Trust _____ Name of Trust _____

Transfer on Death - Individual or joint account that would be transferred to the beneficiary upon the death of individual or all joint owners. Only one beneficiary may be named, which is in accordance with the Security Transfer Association Transfer on Death ("TOD") Rules.

Name of Beneficiary _____
First Middle Initial Last

Mailing Address _____

City _____ State _____ ZIP _____ Social Security Number _____

E-mail Address _____ Daytime Phone Number _____

By signing this form, I/we request enrollment in Otter Tail Corporation Automatic Dividend Reinvestment Plan and Direct Share Purchase Plan (the "Plan"), certify that I/we have received and read the prospectus described the Otter Tail Corporation Dividend Reinvestment Plan and agree to abide by the terms and conditions of the Plan. I hereby appoint Otter Tail Corporation (Shareholder Services) to apply dividends as I/we may instruct and any cash investments I/we may make to the purchase of shares under the Plan. I/we understand that I/we may revoke this authorization at any time by written notice to Shareholder Services.

Signature

Date

Signature

Date

Substitute W-9 Certification of Taxpayer Identification Number (required)

Tax I.D. Number (Social Security or EIN)

Under penalties of perjury, I certify (1) that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and (2) that I am not subject to backup withholding either because (a) I am exempt from backup withholding, or (b) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest of dividends, or (c) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. person (including a U.S. resident alien). *Certification Instructions: If you have been notified that you are subject to backup withholding due to notified payee underreporting and if you have not received a notice from the IRS advising you that backup withholding has terminated, strike out the language in clause 2 above.*

Signature

Date

ELECTRONIC FUNDS TRANSFER AUTHORIZATION (optional). If you would like to purchase additional Otter Tail Corporation common stock for your account automatically through monthly deductions from your checking or savings account, please indicate the amount below. Enrollments received will be included in the following month's investment date. Please complete the information below. **PLEASE PRINT ALL ITEMS.** Cancellation or changes must be made in writing. (Deductions will be made on or about the 15th day of each month).

Type of Account: Checking Savings

Name on Bank Account

Monthly Automatic Investment Amount (*Minimum \$10*)

Name of Bank/Financial Institution

9-digit Routing Number (ABA Number)

Address

Bank Account Number

City, State and Zip Code

Bank Telephone Number

PLEASE ATTACH A VOIDED CHECK TO VERIFY BANKING INFORMATION.