



## Participant Enrollment Governmental 457(b) Plan

### Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA

98966-02

#### Participant Information

Last Name	First Name	MI
<i>(The name provided MUST match the name on file with Service Provider.)</i>		
Mailing Address		
City	State	Zip Code
( ) Home Phone	( ) Work Phone	

Social Security Number					
E-Mail Address					
<input type="checkbox"/> Married		<input type="checkbox"/> Unmarried	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Mo	Day	Year	Mo	Day	Year
Date of Birth			Date of Hire		

**Important Notice:** Employees participating in the Massachusetts Deferred Compensation SMART Plan - OBRA Mandatory Plan (the Plan) must complete Social Security Form SSA-1945. The Plan has been designated as an alternative retirement system for part time employees not covered by their employers retirement system. The SSA-1945 explains the potential effects of the Windfall Elimination Provision and Government Pension Offset Provision under the Social Security law which may reduce the amount of your Social Security retirement or disability benefits, and/or benefits received by you as a spouse or an ex-spouse. If you have any questions regarding SSA-1945 or if you have not completed SSA-1945, please contact your employer.

#### Payroll Information

Town of Maynard Division Name	To be completed by Representative: <u>P&amp;D 6960</u> Division Number
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**Investment Option Information (applies to all contributions)** - Please refer to your communication materials for information regarding each investment option.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure documents for more information.

#### INVESTMENT OPTION NAME

**INVESTMENT  
OPTION CODE  
(Internal Use Only)**

SMART Capital Preservation Fund..... **MELINC..... 100%**

Last Name

First Name

M.I.

Social Security Number

98966-02

Number

## Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable law.

**You may only designate one primary and one contingent beneficiary on this form. However, the number of primary or contingent beneficiaries you name is not limited. If you wish to designate more than one primary and/or contingent beneficiary, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.**

### Primary Beneficiary

**100.00%**

% of Account Balance (        )	Social Security Number	Primary Beneficiary Name	Date of Birth
Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner			

### Contingent Beneficiary

**100.00%**

% of Account Balance (        )	Social Security Number	Contingent Beneficiary Name	Date of Birth
Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner			

## Participation Agreement

**Withdrawal Restrictions** - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

**Compliance With Plan Document and/or the Code** - Participation in this Plan is mandatory. A deduction will be taken from your wages and invested on your behalf based on your employer's Plan Document. I agree that my employer or Plan Administrator may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

**Incomplete Forms** - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option.

**Account Corrections** - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will only be processed from the date of notification forward and not on a retroactive basis.

## Signature(s) and Consent

### Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at:  
<http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>.  
 Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

**Participant Signature**

**Date**

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

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Last Name

First Name

M.I.

Social Security Number

98966-02

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Number**After all signatures have been obtained, this form can be:****Uploaded electronically to:**

Login to account at

**www.mass-smart.com**Click on *Upload Documents* to submit**OR Sent regular mail to:**

Empower Retirement

PO Box 173764

Denver, CO 80217-3764

**OR Sent express mail to:**

Empower Retirement

8515 E. Orchard Road

Greenwood Village, CO 80111

We will not accept hand delivered forms at express mail addresses.

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Participant forward to Service Provider at:

Great-West Retirement Services®

P.O. Box 173764

Denver, CO 80217-3764

Phone #: 1-877-457-1900

Fax #: 1-866-745-5766

Web site: [www.mass-smart.com](http://www.mass-smart.com)