Town of Natick OBRA 457 Deferred Compensation Plan

PARTICPANT ENROLLMENT AGREEMENT

PARTICIPANT NAME:_____ **SSN**:_____

ADDRESS:_____

BIRTH DATE: ___/___/____ **HIRE DATE**: ___/___/____ ❒ **MALE** ❒ **FEMALE** | ❒ **MARRIED** ❒ **UNMARRIED**

EMAIL: _____ **HOME PHONE**: _____ **WORK PHONE**: _____

INVESTMENT & DEFERRAL OPTION INFORMATION (applies to all contributions)

Investment Option Name	**Deferral Amount**
Gartmore Morley Stable Value Fund	_____ %

PLAN BENEFICIARY DESIGNATION

This designation is effective upon execution. 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 state law.

The number of primary or contingent beneficiaries you name is not limited. If you need additional space, please complete this section using an additional Participant Enrollment Agreement.

PRIMARY BENEFICIARIES

% of Account Balance	SSN	Beneficiary Name	Relationship	Date of Birth

CONTIGENT BENEFICIARIES

% of Account Balance	SSN	Beneficiary Name	Relationship	Date of Birth

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/Trustee 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 the 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/Trustee 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 sole liability for any tax, penalty, or costs that may be incurred.

Required Signatures – I have completed, understand and agree to all pages of this Participant Enrollment Agreement.

_____ _____

Participant's Signature **Date**

_____ _____

Authorized Plan Administrator/Trustee Signature **Date**