

# 457b Deferred Compensation Enrollment Form

Return this form to Human Resources,

400 E. Main Street, 3rd Floor, Stockton CA 95202

Fax Number: 209-937-8558

## Section A - Plan and Participant Information

Account No <b>61361-1-1</b>	Social Security Number	Employer <b>City of Stockton 457b</b>	Employee ID:
Participant Name (Last, First, M.I.)		Daytime Phone Number	
Mailing Address	City	State	Zip Code
E-mail	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Hire Date Date of Birth

## Section B - Contributions

### Elective Deferral Per Pay Period (\$10.00 Minimum)

- BEFORE TAX:** I elect to contribute \$ \_\_\_\_\_ or \_\_\_\_\_ % of my compensation each payroll period on a before-tax basis.
- I do not elect to contribute a portion of my salary at this time.

## Section C - Investment Elections

**Future** contributions will be invested in an age-based target investment option. You may select an investment option from the investments made available to your plan. To make any investment elections or changes please visit [www.retiresmart.com](http://www.retiresmart.com) or call 1-800-743-5274. *The employee acknowledges that they have had an opportunity to review the important plan disclosures included in the plan welcome/enrollment package previously delivered to the employee, and that important plan disclosure information can also be obtained by contacting MassMutual at 1-800-743-5274 or linking to Account Access from [www.massmutual.com/cityofstockton](http://www.massmutual.com/cityofstockton).*

## Section D - Beneficiary Designation

I designate the following beneficiary(ies) in accordance with the 457(b) Deferred Compensation Plan

Primary Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
<b>PRIMARY TOTAL:</b>				<b>100%</b>

Contingent Beneficiary (optional): If no Primary Beneficiary listed above is alive upon my death, I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100 %.)

Contingent Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
<b>CONTINGENT TOTAL:</b>				<b>100%</b>

NOTE: If you are married and designate your spouse for less than 100% of your death benefit, you must complete a full Beneficiary Designation/ Spousal Consent form. You can obtain this form from the Human Resources Department.

NOTE: MassMutual will not display Contingent Beneficiary information on our participant website at [www.retiresmart.com](http://www.retiresmart.com). An electronic copy of this form is kept on record.

## Section E - Employee Agreement and Signature

If elected above, I authorize that any Before-Tax Contributions indicated above be made by reducing the Employee's net pay. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 457(b) contributions to ensure the Plan satisfies the requirements of Section 457(b). The execution and the delivery of this form to the offices of MassMutual revokes all prior beneficiary designations that I have made. I understand that this beneficiary designation will not take effect until it has been received in good order by MassMutual.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

## Section F - Important Information

### BENEFICIARY INFORMATION

Please complete the Beneficiary Designation including name, address, phone number, Social Security Number, date of birth, relationship and percentage of death benefit. The percent of benefit must total 100% for all primary beneficiaries named. If naming contingent beneficiary(ies) the total percentage for this designation must equal 100%. Married residents of community property states may want to seek legal advice if naming a non-spouse Primary Beneficiary.

Type of Beneficiary:	Examples of Designations:
One Beneficiary	Jane Doe, wife, 100%
Two or more Primary Beneficiaries, equally among the survivors	John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivors
Two or more Primary Beneficiaries, with their share to their children	John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% per stirpes
Primary and Contingent Beneficiaries	Primary: Jane Doe, wife, 100% if living; Contingent: John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% Either: equally among the survivors Or: <u>per stirpes</u>
Participant's Estate	Participant's Estate
Trustee	Jane Doe, trustee under trust agreement* dated...
* Date of the execution of the trust agreement or a copy of the trust agreement must be provided.	



## DEFERRED COMPENSATION PAYROLL CONTRIBUTION FORM

As a participating employee in the Deferred Compensation plan, who has executed a City of Stockton Participation Agreement, I hereby cancel the prior payroll contribution authorization and designate the new pre-tax payroll contribution, per payday, as stated below:

**Employee Contribution to the 457 Plan:**

Please indicate contribution amount PER PAYDAY: \$ \_\_\_\_\_ OR % \_\_\_\_\_

**Effective Payday:** \_\_\_\_\_

[ ] It is my intent, based on IRS. regulations, to have the maximum allowable contributions into my City of Stockton Deferred Compensation Plan. I understand that my annual contributions are not to exceed the IRS maximum limits set each year.

[ ] Date of Birth \_\_\_\_\_ (Required for Special Catch-Up contributions only)

[ ] Catch-Up- Effective Years \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Please PRINT Name Clearly

\_\_\_\_\_  
Social Security Number

Please return to Human Resources for processing.

**Employer Use Only:**

Choose One:  Start  Change  Stop Max \$ \_\_\_\_\_ Effective Payday: \_\_\_\_\_

Choose One ABT Code:  HA  HC  EP  EC Date Sent to Payroll: \_\_\_\_\_

Date Entered into HTE: \_\_\_\_\_ By: \_\_\_\_\_ Verified By: \_\_\_\_\_ Date: \_\_\_\_\_