

**Participant Enrollment
Governmental 457(b) Plan**



Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA

98966-02

Participant Information

Last Name		First Name	MI	Social Security Number					
Address - Number & Street						E-Mail Address			
City		State	Zip Code	☐ Married	☐ Unmarried	☐ Female	☐ Male		
Mo Day Year		Mo Day Year		Mo Day Year		Mo Day Year			
Date of Birth		Date of Hire							
Home Phone		Work Phone							

Payroll Information

Lexington Public Schools	To be completed by Representative:	6977
Division Name		Division Number

Investment Option Information (applies to all contributions) - Please refer to your marketing 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
The Income Fund	MELINC
	100%
MUST INDICATE WHOLE PERCENTAGES	
=100%	

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 state 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	Relationship	Date of Birth
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Contingent Beneficiary

100.00%	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
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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 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/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 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.



Last Name

First Name

MI

Social Security Number

Required Signatures - 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.ustreas.gov/offices/eotffc/ofac>. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Participant Signature

Date

Employer: forward to Service Provider at:

Great-West Retirement Services®

PO Box 173764

Denver, CO 80217-3764

Express Address:

8515 E. Orchard Road, Greenwood Village, CO 80111

Phone #: 1-877-457-1900

Fax #: 1-866-745-5766