NOTICE TO PART-TIME, SEASONAL, AND TEMPORARY EMPLOYEES
(Not Covered by the Retirement System)

INTERNAL REVENUE SERVICE REGULATIONS ON MEMBERSHIP IN A RETIREMENT SYSTEM---STATE AND LOCAL GOVERNMENT EMPLOYEES

The Omnibus Budget Reconciliation Act of 1990 (OBRA) requires all employees to be covered under (i) the employer's contributory retirement plan, or (ii) social security, or (iii) an alternative retirement plan as defined in the regulations.

Your part-time, seasonal, or temporary employment status does not meet the minimum requirements for membership in the Contributory Retirement System. Therefore, we are required to withhold from your gross wages and you are required to make contributions to social security <u>or</u> the alternative program , the Town of Wilbraham Employees Deferred Compensation Plan.

As provided by OBRA and IRC Section 457, the following requirements are conditions of your employment.

1. A minimum pre-tax deduction equal to 7.5% of your gross wages to be contributed to the 457 Deferred Compensation Plan. All amounts contributed will be deposited in the Prudential Guaranteed Interest Account investment option under plan. These deposits will be credited with a current interest rate which is declared on a quarterly basis. You will receive semi-annual statements of account (June 30 & December 31) from the Plan Administrator, GreatWest/ BenefitsCorp. If you have any questions, please contact GreatWest at 1-800-596-3384.

2. Contributions and any applicable earnings may be withdrawn upon *separation of service.* Distributions from the Deferred Compensation Plan will be taxed as ordinary income in the year received. Contact the Plan Administrator, GreatWest/BenefitsCorp. at 1-800-596-3384 to request a Payout Request Form if you have terminated and wish to withdraw your funds.

3. If your employment status changes to full-time and you become a member of the contributory retirement plan, your Deferred Compensation plan account may <u>not</u> be withdrawn until you separate service (i.e. termination, retirement, disability, death) relative to your full-time position. You may, however; continue to contribute to the plan on a voluntary basis. You are required to notify the Deferred Compensation Plan Administrator if your employment status changes to full-time.

PLEASE COMPLETE THE ATTACHED ENROLLMENT FORM, *INCLUDING THE DESIGNATION OF YOUR BENEFICIARY,* AND RETURN IT TO THE TREASURER'S OFFICE.

Participant Enrollment
Governmental 457(b) Plan

Town of Wilbraham OBRA Plan

340315-02

Participant Information

Last Name | First Name | MI

Social Security Number

Address - Number & Street

E-Mail Address

City | State | Zip Code

Mo Day Year

Date of Birth

☐ Female ☐ Male

☐ Married ☐ Unmarried

( ) Home Phone

( ) Work Phone

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	
Prudential Fixed Fund	PU-FIX	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

% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
100.00%				

Contingent Beneficiary

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

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 selected by the Plan.

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**

Authorized Plan Administrator/Trustee Signature **Date**

Registered Representative Signature and ID **Date**

Participant forward to Plan Administrator/Trustee.
Plan Administrator 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 #: 1-888-672-7240
Fax #: 1-303-737-4355