

## Retirement Plan

### **OBRA (Governmental 457(b) Plan)**

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

Part-time, seasonal and temporary employment statuses do not meet the minimum requirements for membership in the Contributory Retirement System. Therefore, the Town is required to withhold from gross wages, and employees are required to make contributions to either social security or the alternative program, the Town of Wilbraham Governmental 457(b) Plan.

As provided by OBRA and Internal Revenue Code (IRC) Section 457, the following requirements are conditions of your employment with the Town of Wilbraham as a part-time, seasonal or temporary employee:

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 the plan. These deposits will be credited with an interest rate which is declared on a quarterly basis. You will receive semi-annual statements of account (June 30th and December 31st) from the Plan Administrator, Empower Retirement. If you have any questions, please contact Empower at (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 Contributions and any applicable earnings may be withdrawn upon separation of service.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, Empower Retirement at (800) 596-3384 to request a Payout Request Form if you have terminated your employment with the Town of Wilbraham 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and you become a member of the contributory retirement plan, your deferred compensation plan account may not be withdrawn until you separate from service to the Town (i.e. resignation, retirement, disability or death) relative to your full-time position.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 plan administrator if your employment status changes to full-time.

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

**Town of Wilbraham OBRA Plan**

**340315-02**

**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	

Check box if you prefer to receive quarterly account statements in Spanish.

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		

Do you have a retirement savings account with a previous employer or an IRA?  Yes or  No

**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**

<u>NAME</u>	<u>TICKER CODE</u>	<u>%</u>
Prudential Fixed Fund.....	N/A PU-FIX	100
<b>MUST INDICATE WHOLE PERCENTAGES</b>		<b>= 100%</b>

**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
Phone Number (Optional)	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
Phone Number (Optional)	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 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.

## Signature(s) and Consent

### Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form.

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.*

### Authorized Plan Administrator Approval

### Authorized Plan Administrator Signature

Date

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

### Print Full Name

**After all signatures have been obtained, this form can be:**

**Uploaded electronically to:**

**OR Sent regular mail to:**

**OR Sent express mail to:**

Login to account at

**empowermyretirement.com**

Click on *Upload Documents* to submit

Empower

PO Box 173764

Denver, CO 80217-3764

Empower

8515 E. Orchard Road

Greenwood Village, CO 80111

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

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