Quick Enrollment
Governmental 457(b) Plan

Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA 98966-02

Participant Information

Last Name | First Name | MI

(The name provided MUST match the name on file with Service Provider.)

Social Security Number

Address - Number & Street

E-Mail Address

City | State | Zip Code

❑ Married ❑ Unmarried

❑ Female ❑ Male ❑ Nonbinary ❑ Unspecified

( ) Home Phone

( ) Work Phone

( ) Mobile Phone

Mo Day Year — Date of Birth

Mo Day Year — Date of Hire

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

Important Notice: Employees participating in the Massachusetts Deferred Compensation SMART Plan - OBRA Mandatory Plan (the Plan) must complete Social Security Form SSA-1945. The Plan has been designated as an alternative retirement system for part time employees not covered by their employers retirement system. If you have any questions regarding SSA-1945 or if you have not completed SSA-1945, please contact your employer.

Payroll Information

Employer/Division Number

Employer/Division Number

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.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other

❑ 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.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other

❑ Domestic Partner

Investment Option: By signing this form, my contributions will be allocated to the Plan's default investment fund(s), SMART Capital Preservation Fund, without additional action by me. If I wish to contribute to any of the investment options of the Plan other than the default fund(s), I understand that I must contact my Plan Administrator or local representative to obtain a Participant Enrollment Form. I acknowledge that information about Plan investment options, including prospectuses, disclosure document and Fund Data sheets are available to me through my Plan Administrator or Plan Web site. I understand the risks of investing and that all payments and account values may not be guaranteed and may fluctuate in value.

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 understand that I have the right to direct the investment of my account and that I can change my investment allocation from the Plan's default fund at any time by logging on to my account at www.mass-smart.com or by calling the Voice Response System at 1-877-457-1900.

My Account: 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 from 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 the notification forward and not on a retroactive basis.

Required Signature - By signing this form, I acknowledge that I have previously received detailed information about this Plan from my employer and understand that my participation in the Plan must be in compliance with the Plan Document and/or the Internal Revenue Code. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

X _____ _____

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.

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 **www.mass-smart.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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