

**Salary Deferral Agreement
Governmental 457(b) Plan**

City of Somerville 457 Deferred Compensation Plan

340309-01

Participant Information

Last Name			First Name			MI			Social Security Number															
Address - Number & Street												E-Mail Address												
City				State				Zip Code				Mo			Day			Year			<input type="checkbox"/> Female		<input type="checkbox"/> Male	
()				()								Date of Birth			<input type="checkbox"/> Married		<input type="checkbox"/> Unmarried							
Home Phone						Work Phone																		

Salary Deferral Agreement

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superceded, or the employee ceases to be an eligible employee. This Agreement supercedes all previous agreements.

I understand that I may change the percentage of compensation or dollar amount contributed to the Plan only when and as allowed under the terms of the Plan. I also understand that it is my responsibility to comply with the Internal Revenue Code deferral limits.

Payroll Information

Specify one of the following:

- New Enrollment Restart Increase Payroll Deduction Decrease Payroll Deduction Stop Deductions

Specify the following:

- I elect to contribute \$ _____ (per pay period) of my compensation as before-tax contributions to the Governmental 457(b) Deferred Compensation Plan until such time as I revoke or amend my election.

Payroll Effective Date: _____
Mo Day Year

Date of Hire: _____
Mo Day Year

Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Payroll Center Name

Payroll Center Number

Multiple Recordkeepers

Specify recordkeeper name(s) and dollar amount you wish to allocate per pay period.

RECORDKEEPER NAME:	\$ PER PAY PERIOD:
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____

Your Consent and Signature

I have completed, understand and agree to the terms of this Agreement and authorize the payroll deduction as indicated on this form. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Participant Signature

Date

Participant forward to Plan Administrator/Trustee



Last Name

First Name

MI

Social Security Number

Authorized Signature(s)

Authorized Plan Administrator/Trustee Signature

Date

Plan Administrator forward to Service Provider at:

City of Somerville

93 Highland Avenue

Somerville, MA 02143

Phone #: 1-888-672-7240

Web site: www.gwrs.com

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