OBRA

Enrollment Form 457(b) Governmental

MassMutual Retirement Services
PO Box 1583, Hartford, CT 06144-1583
Fax Number: 877-526-2531 or 800-678-8645

Group No: 109993		Social Security No:	
Employer: Town of Bourne		Dept/ Location:	
Employee Name: (*Last, First, M.I.*)			
Mailing Address:			
City:		State:	Zip:
Home Phone:	Work Phone:	Date of Birth:	Date of Hire:

Sex: ☐ M ☐ F

A. CONTRIBUTIONS

	$ or % Amount		Frequency*		Annual Contibution		Total
Employee	7.50%	X	—	=	—	=	—

Current Annual Salary $ —

☐ I am utilizing the plan's age 50+ catch-up provision

☐ I am utilizing the plan's pre-retirement catch-up provision.
My unused deferral limitation is $_____
My anticipated retirement date is __/__/____

*** Frequency**

Monthly	=	12
Bi-Weekly	=	26
Semi-Monthly	=	24
Weekly	=	52
Other: _____		

B. SIGNATURES

I understand that all values provided by the contract, when based on investment experience of the above named investment choices (except the General Account), are variable and are not guaranteed as to a fixed dollar amount. Receipt of a currently effective variable annuity prospectus or disclosure document, whichever is applicable, is acknowledged. Further I wish to participate in the Deferred Compensation Plan and hereby agree to defer my right to receive compensation to the extent of the annual premium noted above. I understand and agree to the provisions contained in my Employer's Deferred Compensation Plan. Together with my heirs, successors, and assigns, I will hold harmless my Employer from any liability hereunder for all acts performed in good faith, including those related to the investment of deferred amounts and/or my Employer's investment preference(s) under my Employer's Deferred Compensation Plan. I acknowledge that I have read and understand the Full Disclosure Statement, as applicable to my state, located on the last page of this form.

Signed in the state of MA on _____
Date

_____
Participant Signature

This document has been received and accepted by the Plan Administrator.

Karen E Shoriard _____
Plan Administrator Signature Date

Sylvia A. Connor Sylvia A. Connor
Printed Name of Registered Representative Registered Representative Signature

ACX5219000
Registered Representative Tax ID/Producer Code

_____
Selling Firm Name Selling Firm Tax ID

C. INVESTMENT ELECTION

I elect to have all future contributions invested among the investment options I have selected below. I understand that this Enrollment Form is to be used to record my initial investment option election and may not be used for investment option transfers or investment option allocation changes. To make investment changes please call 1-800-528-9009 or visit massmutual.com/serve.

SECTION 1
Selections must be in whole percentages totaling 100%.

100 % 10 General Account

100%

All investment options may not be available in all jurisdictions. Please consult your Plan Sponsor to determine which are available.

Beneficiary Designation/ Name & Address Change - 457(b) and 401(a)

Mail Address:
MassMutual Retirement Services
PO Box 1583
Hartford, CT 06144-1583

Overnight Mail Address
MassMutual Retirement Services
1 Griffin Road North
Windsor, CT 06095-1512

Group Number:	Social Security Number:	Employer:
109993		Town of Bourne

Employee Name: *Last, First,M.I.*
☐ Name Change? Please provide documentation

Mailing Address:
☐ New?

City:	State:	Zip:

Home Phone:	Work Phone:	Ext:

BENEFICIARY INFORMATION

Please complete the Beneficiary Designation including name, address, phone number, Social Security Number, date of birth, relationship and percentage of death benefit. The percent of benefit must total 100% for all primary beneficiaries named. If naming contingent beneficiary(ies) the total percentage for this designation must equal 100%. Married residents of community property states may want to seek legal advice if naming a non-spouse Primary Beneficiary.

Type of Beneficiary:		**Examples of Designations:**
One Beneficiary		Jane Doe, wife, 100%
Two or more Primary Beneficiaries, ***equally among the survivors***		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivors
Two or more Primary Beneficiaries, ***with their share to their children***		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% per stirpes
Primary and Contingent Beneficiaries	***either***	Primary: Jane Doe, wife, 100% if living; Contingent: John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% equally among the survivors
	or	per stirpes
Participant's Estate		Participant's Estate
Trustee		Jane Doe, trustee under trust agreement* dated...

** Date of the execution of the trust agreement or a copy of the trust agreement **must** be provided.*

Primary Beneficiary(ies) name, address and phone no.	Social Security No.	Date of Birth	Relationship	%
			PRIMARY TOTAL:	**100%**

Contingent Beneficiary(ies) name, address and phone no.	Social Security No.	Date of Birth	Relationship	%
			CONTINGENT TOTAL:	**100%**

The execution and the delivery of this form to the offices of MassMutual revokes all prior beneficiary designations that I have made. I understand that this beneficiary designation will not take effect until it has been received in good order by MassMutual.

Employee Signature _____ Date _____

Mail this Beneficiary Designation to MassMutual at the address above. Keep a copy for your records.

HVL-464-3 Rev. 4.13 ***Please provide a copy of this Beneficiary Designation to your Employer.*** benedcp.pdf