



Participant Enrollment
Governmental 457(b) Plan

Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA

98966-02

Participant Information

Form with fields for Last Name, First Name, MI, Social Security Number, Address, City, State, Zip Code, Home Phone, Work Phone, E-Mail Address, Date of Birth, Date of Hire, and marital status options.

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.

Statement Delivery - Participant quarterly statements are sent regular mail via the U.S. Postal Service. If you prefer an environmentally friendly alternative, please visit www.mass-smart.com for fast and easy enrollment in our Online File Cabinet service.

Payroll Information

Form with fields for Division Name and Division Number, and a line for the representative to be completed by.

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.

Table with columns: INVESTMENT OPTION NAME, INVESTMENT OPTION CODE (Internal Use Only). Row 1: The Income Fund, MELINC, 100%



Last Name

First Name

MI

Social Security 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 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

100.00%

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

100.00%

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

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. 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.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made. I verify that this enrollment was unsolicited. I did not meet with a representative on a one-on-one basis regarding investment options.

Participant Signature

Date

Participant forward to Service Provider at:
Great-West Retirement Services®
P.O. Box 173764
Denver, CO 80217-3764
Phone #: 1-877-457-1900
Fax #: 1-866-745-5766
Web site: www.mass-smart.com

Great-West FinancialSM refers to products and services provided by Great-West Life & Annuity Insurance Company; Great-West Life & Annuity Insurance Company of New York, White Plains, New York; their subsidiaries and affiliates. Great-West Retirement Services® refers to products and services provided by Great-West Life & Annuity Insurance Company, FASCore, LLC (FASCore Administrators, LLC in California), Great-West Life & Annuity Insurance Company of New York, White Plains, New York, and their subsidiaries and affiliates. Great-West Life & Annuity Insurance Company is not licensed to conduct business in New York. Insurance products and related services are sold in New York by its subsidiary, Great-West Life & Annuity Insurance Company of New York. Other products and services may be sold in New York by FASCore, LLC.



**Criminal Offender Record Information (CORI)
 Acknowledgement Form**

To be used by organizations conducting CORI checks for employment, volunteer, subcontractor, licensing, and housing purposes.

_____ is registered under the

 (Organization)
 provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to _____

 (Organization)

to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____

 (Organization)
 with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The _____ may conduct

 (Organization)
 subsequent CORI checks within one year of the date this Form was signed by me, provided, however, that
 _____,

 (Organization)
 with written notice of this check.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature of CORI Subject

Date



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services**
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS



SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: ____ -- ____ No Social Security Number

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

Verified by:

Print Name of Verifying Employee

Signature of Verifying Employee

Date