

# ***Natick Public Schools***

13 East Central Street  
Natick, Massachusetts 01760  
FAX (508) 647-6506

*Building the Future, One Child at a Time*

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**Peter J. Sanchioni, Ph.D**  
*Superintendent*  
(508) 647-6500

**Marianne E. Davis**  
*Director of Human Resources*  
(508) 647-6495

**To:** All Part-Time, Temporary or Seasonal Employees

**From:** Marianne E. Davis

## **IMPLEMENTATION OF THE OBRA ACT OF 1990 Effective January 1, 1992**

On December 9, 1991, the Natick Board of Selectmen voted to provide all part-time, temporary and seasonal employees with a "meaningful retirement plan" per requirements of the Federal Government effective January 1, 1992. The vehicle the Selectmen chose was to place these employees in a Deferred Compensation 457 Plan. This plan is in lieu of social security.

All OBRA employees' withholdings will be invested with the Prudential Insurance Company. The Prudential Insurance offers a guaranteed interest account which means the company will guarantee the interest earned on the employees contributions.

The rate of minimum contributions made by the employee per pay periods is 7.5%. You may contribute a greater amount up to a maximum of 25% per pay period. Although the Town of Natick is required by law to make this deduction from your paycheck, the money is still yours and will be invested on your behalf by the plan administrator.

Our plan administrator is Benefits Corporation/Great-West Retirement Services [www.gwrs.com](http://www.gwrs.com) and our Natick representative is Rob Young at 1-800-596-3384 ext. 77978 or [robert.young@gwrs.com](mailto:robert.young@gwrs.com). Upon termination of your employment with the Town of Natick, you may also request a refund through the company.

This Deferred Compensation 457 Plan is mandatory and the attached enrollment form must be completed and returned to Human Resources.

*Revised 4/11/08*

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

**Town of Natick OBRA 457 Deferred Compensation Plan**

340303-02

**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
( ) Home Phone		( ) Work Phone		Date of Birth		<input type="checkbox"/> Married		<input type="checkbox"/> Unmarried	

**Investment Option Information (applies to all contributions)** - Please refer to your marketing 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.

<u>INVESTMENT OPTION NAME</u>	<u>INVESTMENT OPTION CODE</u>	
Prudential Fixed Fund .....	PU-FIX	___ %
<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 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 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.



_____	_____	_____	_____
Last Name	First Name	MI	Social Security Number

**Required Signatures** - 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.ustreas.gov/offices/eotffc/ofac>. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Plan Administrator/Trustee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Registered Representative Signature and ID

\_\_\_\_\_  
Date

**Participant forward to Plan Administrator/Trustee**  
**Plan Administrator forward to Service Provider at:**  
Great-West Retirement Services®  
PO Box 173764  
Denver, CO 80217-3764  
**Express Address:**  
8515 E. Orchard Road, Greenwood Village, CO 80111  
**Phone #:** 1-888-672-7240  
**Fax #:** 1-303-737-4355