MassMutual

Enrollment Form 457(b) Governmental

MassMutual, PO Box 1583, Hartford, CT 06144-1583 Fax No.:877-526-2531 or 800-678-8645

Group No: 150163	Social Security No:
Employer: Stanislaus County	Dept/ Location:

Employee Name: (*Last, First, M.I.*)

*Mailing Address:

City:	State:	Zip:	Sex: ☐ M ☐ F
Home Phone: / Work Phone:	Date of Birth:	Date of Hire:	

*For your mailing address, provide either a street address or P.O. Box, not both. If you provide both, MassMutual will follow USPS Guidelines and use the PO Box as your mailing address.

A. CONTRIBUTIONS

	$ or % Amount	*Frequency**	*Annual Contibution*	*Total*
Employee		X	=	=
** Roth After Tax*		X	=	

Current Annual Salary $

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

☐ I am utilizing the plan's age 50+ catch-up provision
If you are utilizing the plan's pre-retirement catch-up provision, contact a MassMutual representative to request a form.

*I understand that once an amount is contributed, its designation as a Roth contribution may not be changed.

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 contribution 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 Fraud Warning Statement, as applicable to my state, located on the last page of this form.

Signed in the state of _____on_____
Date

_____
Participant Signature

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

_____
Plan Administrator Signature Date

TO BE COMPLETED BY THE REGISTERED REPRESENTATIVE
(For Home Office Administration Purposes Only)

_____
Printed Name of Registered Representative Registered Representative Signature

_____
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%.

_____% 5X American Century Equity Income I
_____% 5Y American Funds The Growth Fund of America R5
_____% DC Bank of the West Insured Deposit Option I
_____% 1N Calvert VP SRI Balanced Portfolio
_____% 41 General Account
_____% 1J Hartford Capital Appreciation HLS IA
_____% 1C Hartford Dividend and Growth HLS IA
_____% 3P Hartford Global Growth HLS IA
_____% 4E Hartford Healthcare HLS IA
_____% 1M Hartford International Opportunities HLS IA
_____% 2Q Hartford MidCap HLS IA
_____% 1B Hartford Total Return Bond HLS IA
_____% JA Hood River Small Cap Growth Ret
_____% 8W Invesco Equity and Income Y
_____% JR Invesco Real Estate R5
_____% KI JPMorgan SmartRetirement 2020 A
_____% IT JPMorgan SmartRetirement 2025 A
_____% IU JPMorgan SmartRetirement 2030 A
_____% IV JPMorgan SmartRetirement 2035 A
_____% IW JPMorgan SmartRetirement 2040 A
_____% IX JPMorgan SmartRetirement 2045 A
_____% IY JPMorgan SmartRetirement 2050 A
_____% IZ JPMorgan SmartRetirement Income A
_____% 5U MFS Utilities R4
_____% 4U Oppenheimer Global A
_____% 2T Putnam High Yield Y
_____% RK State Street Intl Index Sec Lend Series T
_____% RJ State Street Russell Sml Cp Index Sec Lend A
_____% RH State Street S&P MC Index Non-Lend Series A
_____% LA Vanguard Institutional Index Inst
_____% Y8 Vanguard Total Bond Market Index Admiral
_____% XR Westwood SmallCap Value Inst

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

Fraud Warning Statements

The following states require insurance applicants to acknowledge a fraud warning statement specific to that state. Please refer to the specific fraud warning statement for your state as indicated below. If your state is not separately listed, please refer to the NAIC Model Fraud Statement below.

NAIC Model Fraud Statement - Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas and West Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Services.

District of Columbia - Warning: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty or a crime and may be subject to fines and confinement in prison.

New Jersey - Any person who knowingly includes any false or misleading information on an application for an insurance policy, or files a statement of claim containing any false or misleading information, is subject to criminal and civil penalties.

New Mexico for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Oklahoma - Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon - Any person who knowingly , and with INTENT TO DEFRAUD or solicit another to defraud an insurer (1) by submitting an application , or (2) by filing a claim containing a false statement as to any MATERIAL FACT, MAY BE violating state law.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia and Washington - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MassMutual

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

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

Group Number: 150163	Social Security Number:	Employer: Stanislaus County

Employee Name: *Last, First,M.I.*

☐ Name Change? Please provide documentation

*Mailing Address: ☐ New?	Daytime Phone:	
City:	State:	Zip:

*For your mailing address, provide either a street address or P.O. Box, not both. If you provide both, MassMutual will follow USPS Guidelines and use the PO Box as your mailing address.

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.

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

Employee Signature _____ Date _____