

Enrollment Form 457(b) Governmental

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

Fax Number: 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: <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone:	Work Phone:	Date of Birth:	Date of Hire:

A. CONTRIBUTIONS

Employee	\$ or % Amount	X	Frequency*	=	Annual Contribution	=	Total
	<input type="text"/>	X	<input type="text"/>	=	<input type="text"/>	=	<input type="text"/>
* Roth After Tax	<input type="text"/>	X	<input type="text"/>	=	<input type="text"/>	=	<input type="text"/>

Current Annual Salary \$

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.

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

*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 INV
- % 5Y American Funds The Growth Fund of America R4
- % 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
- % 1I Hartford Small Company HLS IA
- % 1B Hartford Total Return Bond HLS IA
- % 8W Invesco Equity and Income A
- % JR Invesco Real Estate A
- % IS JPMorgan SmartRetirement 2015 A
- % 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 A
- % 4U Oppenheimer Global A
- % 2T Putnam High Yield Advantage Y
- % RK State Street Intl Index Sec Lend Series II
- % RJ State Street Russell Sml Cp Index Sec Lend II
- % RH State Street S&P MC Index Non-Lend Series II
- % LA Vanguard Institutional Index Inst
- % Y8 Vanguard Total Bond Market Index Admiral
- % XR Westwood SmallCap Value Inst

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)

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Group Number: 150163	Social Security Number:	Employer: Stanislaus County
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Employee Name: *Last, First, M.I.*

Name Change? Please provide documentation

Mailing Address: <input type="checkbox"/> New?	Daytime Phone:
City:	State: Zip:

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:

- One Beneficiary
- Two or more Primary Beneficiaries,
equally among the survivors
- Two or more Primary Beneficiaries,
with their share to their children
- Primary and Contingent Beneficiaries

Examples of Designations:

- Jane Doe, wife, 100%
- John Doe, son, 33%
- Carol Smith, daughter, 33%
- Mark Doe, son 34%
or equally among the survivors
- John Doe, son, 33%
- Carol Smith, daughter, 33%
- Mark Doe, son 34%
per stirpes
- Primary: Jane Doe, wife, 100% if living;
Contingent: John Doe, son, 33%
- Carol Smith, daughter, 33%
- Mark Doe, son 34%
equally among the survivors
per stirpes
- Participant's Estate
- Jane Doe, trustee under trust agreement* dated...

**either
or**

- Participant's Estate
- Trustee

* 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-464-4 Rev. 2.15	benedcp.pdf
Please provide a copy of this Beneficiary Designation to your Employer.	

MassMutual Financial Group is a marketing name for Massachusetts Mutual Life Insurance Company (MassMutual) (of which Retirement Services is a division) and its affiliated companies and sales representatives.