457 Plan & Trust
Enrollment Form

This and other important forms are available at:
www.jemtpa.com

EMPLOYER NAME: _____

Check Appropriate Boxes:

❑ Initial Enrollment ❑ Restart ❑ Enrollment Increase ❑ Enrollment Decrease ❑ Investment Option Change ❑ Change ❑ Address Change ❑ Beneficiary Change

Participating Employee: _____ **Social Security Number:** _____ **Birth date:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone #: _____ **Work Phone:** _____ **E-mail Address:** _____

Enter the Dollar Amount to Be Contributed For Each Investment Option Chosen

Investment Options	**Deferral**
_____	$_____
_____	$_____
_____	$_____
_____	$_____
Total Election Amount	$_____

Payroll Frequency:
Monthly Semi-Monthly
Bi-Weekly Weekly Other _____
Beginning With Payroll Date: _____
Election Amount:
(equals total election amount at left) **$**_____
Administration Fee: + **$**_____
_____
Total Deduction Amount: = **$**_____
(Per Pay Period)

Primary Beneficiary **Name:** 457 Trust

Participant's Primary Beneficiary **Name:** _____ **Relationship:** _____

• **Male** • **Female** **Birth Date:** _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Participant's Contingent Beneficiary **Name:** _____ **Relationship:** _____

• **Male** • **Female** **Birth Date:** _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

❑ **If additional Participant Beneficiaries are desired, please indicate here and attach a separate sheet. Please be sure to include the Name, Relationship, Gender, Date of Birth and complete mailing address.**

By signing this form I acknowledge the following:
(a) I am participating in a Plan and Trust maintained under Section 457(b) of the Internal Revenue Code (the "Code"), (b) I agree to comply with the rules of the Plan as defined by the Code and my Employer (c) I understand that I can receive a copy of the 457 Plan Document from my Employer that defines all rules applicable to my account by requesting a copy of the Document, (d) the Employer has no responsibility or liability for my choice of a company(ies) and/or investment or insurance product(s) to which my contributions shall be directed, (d) I will not request any withdrawals from my 457 account(s) or receive any distributions of any kind from such accounts that do not meet the requirements of Section 457 of the Code, (e) this Agreement replaces any and all prior or existing 457 salary reduction and/or payroll deduction agreements by and between my Employer and me, (g) this Agreement shall be renewed automatically each Plan year unless cancelled by me in writing and (h) my Employer has my permission to modify or stop my 457 salary reduction amount without my written permission if such action is necessary to comply with Plan rules.
Signature of Participating Employee: _____ **Date:** _____

Name of Representative: _____ **Date:** _____ **Phone #** _____

Representative's Address: _____ **Representative's Email Address** _____

Employer's Acknowledgement: _____ **Date:** _____