Print Form

Clear Form

Sonoma County Deferred Compensation - 0041611
Participation Agreement

Nationwide Retirement Solutions

☐ 457 ☐ 401(a)

☐ Initial Enrollment ☐ Change in Deferral Amount ☐ Re-Enrollment ☐ Change of Address ☐ Beneficiary Change ☐ Name Change

PARTICIPANT INFORMATION

Name _____ (Last / First / Middle)

Address _____ (Number / Street)

_____ (City / State / Zip)

Social Security No. _____

Date of Birth _____

Work Phone (_____)_____

Home Phone (_____)_____

Email Address _____

The employer has established a deferred compensation plan for the benefit of its employees. The plan provides that eligible employees may elect to join and become a participant in the plan (subject to the limitations established in the plan of the employer) upon executing and filing a participation agreement with the employer. Participants may request a copy of the plan document from the employer.

DEFERRAL AMOUNT

Total deferral amount per pay period $_____

Starting _____/_____/_____

Includible Compensation $_____

Employee Number _____

Department _____

INVESTMENT OPTION(S)

1. _____ (___%) 5. _____ (___%)
2. _____ (___%) 6. _____ (___%)
3. _____ (___%) 7. _____ (___%)
4. _____ (___%) 8. _____ (___%)

Current Prospectus Received _____ Initial

*Please note: If the total investment option allocation percentage equals less than 100%, the difference will be invested in the default option, the Liquid Savings Account. If the total investment option percentage is greater than 100%, your application will be rejected and your Participation Agreement will not be processed.

☐ Enroll me in asset rebalancing. I agree to comply with and be bound by the terms and conditions of the service including any restrictions imposed by the investment options. I understand I can obtain more information about the service, its terms and conditions by contacting the NRS Service Center.

Catchup Provision Utilized: ☐ No ☐ Yes (50 and over) If yes, provide Normal Retirement Age: _____

DESIGNATION OF BENEFICIARY

I hereby designate the following as my beneficiary(ies) under the above named deferred compensation plan subject to my right to change this designation as provided in said plan. The split must be in whole % and must equal 100% for each category of beneficiary (i.e., primary and contingent). If no % listed, it will be split equally among named beneficiaries.

Primary Beneficiary(ies)

1.
Beneficiary SS# _____ Date of Birth _____
Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ _____%

2.
Beneficiary SS# _____ Date of Birth _____
Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ _____%

Contingent Beneficiary(ies)

1.
Beneficiary SS# _____ Date of Birth _____
Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ _____%

2.
Beneficiary SS# _____ Date of Birth _____
Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ _____%

Liquid Savings and Certificate of Deposit products are FDIC insured to at least $250,000 per depositor. The Galliard Stable Value fund is a bank collective fund, trusteed by Norwest Bank of Minnesota, N.A. and managed by Galliard Capital Management, a wholly owned subsidiary of Norwest Bank of Minnesota, N.A. Mutual fund products and the Galliard Stable Value fund are not FDIC insured, are not deposits or other obligations of, or guaranteed by any bank, and are subject to investment risk.

I authorize my employer to reduce my salary by the above amount which will be credited to the public employee deferred compensation plan. The reduction will continue until otherwise authorized in accordance with the plan. The withholding of my contributed amount by my employer and its payment to the designated investment option(s) will be reflected as early as administratively practicable but not earlier than the first calendar month following the execution of this Participation Agreement. The reduction is to be allocated to the funding options in the percentages indicated above. Some mutual funds may impose a short term trade fee. Please read the underlying prospectuses carefully.

I HAVE READ AND UNDERSTAND EACH OF THE STATEMENTS ON THE FRONT AND BACK OF THIS FORM, WHICH ARE INTENDED TO COMPLY WITH SECTION 457 OF THE INTERNAL REVENUE CODE. I ACCEPT THESE TERMS AND UNDERSTAND THAT THESE STATEMENTS DO NOT COVER ALL THE DETAILS OF THE PLAN OR PRODUCTS.

_____ Signature of Participant _____ Date _____ Principal Signature

_____ Authorized Signature/Employer _____ Date _____ Retirement Specialist _____ Rep. #

DC-4920-0712

COPY 1- Processing, COPY 2- Employer, COPY 3- Retirement Specialist, COPY 4- Participant