



Participant Enrollment
Governmental 457(b) Plan

Commonwealth of Pennsylvania Deferred Compensation Program

98978-01

Participant Information

Form with fields for Last Name, First Name, MI, Social Security Number, Address, City, State, Zip Code, Home Phone, Work Phone, E-Mail Address, Date of Birth, and checkboxes for Female, Male, Married, Unmarried.

Payroll Information

Form with checkboxes for contribution election, Payroll Effective Date, and Date of Hire.

Form with fields for Division Name and Division Number, labeled 'To be completed by Representative'.

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.

Table with 4 columns: INVESTMENT OPTION NAME, INVESTMENT OPTION CODE, INVESTMENT OPTION NAME, INVESTMENT OPTION CODE. Lists various funds like Aggressive Portfolio Fund, Moderate Portfolio Fund, etc.

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.

I understand that the Plan is a retirement savings plan and is not intended to replace an adequate savings program necessary for pre-retirement expenses. However, I also understand that I may be eligible to receive a distribution at any time in the event of an unforeseeable financial emergency. I understand that unforeseeable emergency withdrawals are allowable only in the event of loss of my property due to casualty, illness or accident involving me or my dependent, payment of medical expenses related to me or my dependent, foreclosure or eviction from my residence, payment of funeral expenses of a spouse or dependent, or my lost wages. I also understand that I must have exhausted all other financial means available to me in order to be approved for an unforeseeable emergency withdrawal from my Plan account. I further understand that I must request a withdrawal for unforeseeable emergency on a separate form to which I must attach documentation supporting my request for such a withdrawal.

Investment Options - I understand that by signing and submitting this Participant Enrollment form for processing, I am requesting to have investment options established under the Plan as specified in the Investment Option Information section. I understand and agree that this account is subject to the terms of the Plan Document. I understand and acknowledge that all payments and account values, when based on the experience of the investment options, may not be guaranteed and may fluctuate, and, upon redemption, shares may be worth more or less than their original cost. I acknowledge that investment option information, including prospectuses, disclosure documents and Fund Profile sheets, have been made available to me and I understand the risks of investing.

Compliance With Plan Document and/or the Code - 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. If no default investment option is selected, funds will be returned to the payor as required by law. Once an account has been established on my behalf, I understand that I must call KeyTalk[®] or access the Web site in order to transfer monies from the default investment option. Also, I understand all contributions received after an account is established on my behalf will be applied to the investment options I have most recently selected.

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.

Required Signature - I have completed, understand and agree to all pages of this Participant Enrollment form. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Participant Signature	Date
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Participant forward to Service Provider at:
 Great-West Retirement Services[®]
 301 Chestnut St., Suite 402
 Harrisburg, PA 17101
Phone #: 1-866-737-7457
Fax #: 1-717-901-3620
Web site: www.sers457.com

Representative must check one of the following.

Solicited: Representative met with individual participant to solicit enrollment and has verified suitability of allocation per participant's investment objectives

Unsolicited: Representative did not meet with participant

Registered Representative Signature and ID	Date
Registered Principal Signature	Date



Salary Deferral Agreement
Governmental 457(b) Plan

Commonwealth of Pennsylvania Deferred Compensation Program

98978-01

Participant Information

Form with fields for Last Name, First Name, MI, Social Security Number, Address, City, State, Zip Code, Home Phone, Work Phone, E-Mail Address, Date of Birth, and Department of Employment.

Salary Deferral Agreement

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superceded, or the employee ceases to be an eligible employee.

I understand that I may change the dollar amount contributed to the Plan only when and as allowed under the terms of the Plan.

Ongoing Payroll Deductions Only: (Do not complete for Sick and Annual Leave Payouts. See below.)

Specify one of the following:

- Checkboxes for New Enrollment, Restart, Increase Payroll Deduction, Decrease Payroll Deduction, Stop Deductions, Age 50 Catch-Up, Normal Catch-Up.

Specify the following:

I elect to contribute \$ (per pay period) of my compensation as before-tax contributions to the Commonwealth of Pennsylvania Deferred Compensation Program Plan until such time as I revoke or amend my election.

Pay Date: Mo Day Year

Date of Hire: Mo Day Year

Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Sick and Annual Leave Deduction Only:

Retirement Date

I elect to contribute \$ of my sick and annual leave payout. (Please note: An indication of Whole or Full on this line will not be processed.)

Required Signature - I have completed, understand and agree to the terms of this Agreement and authorize the payroll deduction as indicated on this form.

Participant Signature

Date

Participant forward to Service Provider at: Great-West Retirement Services, 301 Chestnut St., Suite 402, Harrisburg, PA 17101. Phone #: 1-866-737-7457, Fax #: 1-717-901-3620, Web site: www.sers457.com





**Beneficiary Designation
Governmental 457(b) Plan**

Commonwealth of Pennsylvania Deferred Compensation Program

98978-01

Participant Information

Last Name		First Name		MI	Social Security Number	
Address - Number & Street						
City		State		Zip Code		
<input type="checkbox"/> Married		<input type="checkbox"/> Unmarried				
E-Mail Address						
Account Extension Number (if applicable) Account extension identifies funds that were transferred to you through a divorce or death.						

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. If I name more than one beneficiary in either category, the surviving beneficiaries in that category will share equally unless otherwise indicated. 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.

This designation supercedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. Primary and contingent beneficiaries must separately total 100.00%. The number of primary or contingent beneficiaries you may name is not limited. Attach an additional sheet if necessary.

Primary Beneficiary

#1	.	% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
#2	.	% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
#3	.	% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth

Contingent Beneficiary

#1	.	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
#2	.	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
#3	.	% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth

Required Signature

I have completed, understand and agree to all pages of this Beneficiary Designation 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>.

Participant Signature

Date

Participant forward to Service Provider at:
Great-West Retirement Services®
301 Chestnut St., Suite 402
Harrisburg, PA 17101
Phone #: 1-866-737-7457
Fax #: 1-717-901-3620
Web site: www.sers457.com

