

EMPLOYER: City of Springfield

New Enrollment **Suspension/Cancellation** **Beneficiary Change** **Increase/Decrease**

Participant _____ Social Security No. _____
 Home Address: _____ City _____ State _____ Zip Code _____
 Home Phone (____) _____-____ Work Phone (____) _____-____ Birth Date ____/____/____

1. **Participation.** I wish to participate in the 457 Deferred Compensation Plan and agree to defer compensation as indicated below.
2. **Amount Deferred/Beginning Date.** I elect to defer (**\$ or %**) _____ of my eligible compensation **per pay check**, beginning (Date)_____, or as early as possible after this date, and continuing thereafter for the period of my employment or until changed in writing. I understand that the amount deferred cannot exceed the maximum per calendar year as set forth in IRC §457. I further understand that the Deferred Compensation funds are funds of the Plan and are to be held by the Plan in trust for the exclusive benefit of participants and their beneficiaries.
3. **Investment Preference.** I desire to have the amounts in my Deferred Compensation Account invested with ING Aetna Financial Services.
4. **Time of Payment.** I understand that if I separate from service I may defer the payment date to a date no later than the close of the plan year after I reach age 70-1/2 unless I am still employed under the Plan. I understand that I am eligible to begin payments at separation from service. I will have the ability to change my method of payment quarterly.
 => **(participants initials)** _____
5. **Termination.** The Participation Agreement will terminate automatically upon separation of service. The Sponsor may terminate the Deferred Compensation Plan which will automatically revoke all elections.
6. **Acknowledgment Form.** By entering into this Participation Agreement, I acknowledge that I have received an ING Prospectus and the Plan has been fully reviewed with me by a representative of ING. I understand that by deferring earnings, I am currently deferring the payment of Federal Income Taxes. When I actually receive the money, I will be required to pay taxes at that time as the money is received. I understand that the Deferred Compensation Plan is not like a savings account. Except for emergencies approved by the Plan Administrator, the money will not be available until retirement, termination of employment, death or disability. I understand that if I separate from service prior to attaining retirement age, I may defer the payment date to retirement age. I understand that if I have a financial emergency, I may request from the Plan Administrator the amount of funds needed to meet the immediate hardship. The Plan Administrator has the sole discretion to determine whether an emergency actually exists and how much withdrawal should be allowed to meet the emergency. By entering into this Participation Agreement, I acknowledge that the items above have been explained to me by the representative and that I fully understand them.
 => _____ **(participants initials)**
7. **General Provisions.** This Participation Agreement shall be binding upon the successor and assigns of Employer and upon the legal representatives of the Employee.
8. **Effective Date.** A Participation Agreement becomes effective during the first pay period following the receipt of the signed agreement.

DESIGNATION OF BENEFICIARY

I hereby designate the following individual(s) as my beneficiary(ies) to receive the indicated percentage of benefits which may become due or payable on or after my death under my Employer's Deferred Compensation Plan:

Primary(s): Name _____	Contingent(s): Name _____
Address _____ _____	Address _____ _____
Date of Birth _____	Date of Birth _____
Relationship _____	Relationship _____
Percent of distribution _____	Percent of distribution _____

 Participant's Signature Administrator's Authorized Signature Registered Representative's Signature

Dated _____