



Participant Enrollment
Governmental 457(b) Plan

CCOERA 457 Plan

98721-02

Participant Information

Form fields for Participant Information including Last Name, First Name, MI, Social Security Number, Address, City, State, Zip Code, Home Phone, Work Phone, E-Mail Address, and Date of Birth/Hire.

Payroll Information

I elect to contribute % or \$ (per pay period) of my compensation as before-tax contributions to the Governmental 457(b) Deferred Compensation Plan until such time as I revoke or amend my election.

Payroll Effective Date: Mo Day Year

Required Information

Form fields for Required Information including Employer Name, Employer Number, Agency Name, and Agency Number.

Investment Option Information (applies to all contributions) - Please refer to your 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 (Internal Use Only), INVESTMENT OPTION NAME, and INVESTMENT OPTION CODE (Internal Use Only). Lists various investment options like PIMCO High Yield Fund, Fidelity Contrafund, etc.

MUST INDICATE WHOLE PERCENTAGES = 100%



Last Name

First Name

MI

Social Security Number

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. 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.

You may only designate one primary and one contingent beneficiary on this form. However, the number of primary or contingent beneficiaries you name is not limited. If you wish to designate more than one primary and/or contingent beneficiary, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.

Primary Beneficiary

100.00%

% of Account Balance	Social Security Number	Primary Beneficiary Name	Relationship	Date of Birth
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Contingent Beneficiary

100.00%

% of Account Balance	Social Security Number	Contingent Beneficiary Name	Relationship	Date of Birth
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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.

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 the monies will be transferred from the default investment option and applied according to the allocations on my Participant Enrollment form. I understand that I will not be able to make any changes to my account until my completed Participant Enrollment form has been received.

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.

Last Name

First Name

MI

Social Security Number

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

Participant Signature

Date

Participant forward to Service Provider at:

Great-West Retirement Services®

PO Box 173764

Denver, CO 80217-3764

Express Address:

8515 E. Orchard Road, Greenwood Village, CO 80111

Phone #: 1-800-352-0313

Fax #: 1-866-745-5766

Great-West Retirement Services® refers to products and services provided by Great-West Life & Annuity Insurance Company, FASCore, LLC (FASCore Administrators, LLC in California), First Great-West Life & Annuity Insurance Company, White Plains, New York, and their subsidiaries and affiliates. Great-West Life & Annuity Insurance Company is not licensed to conduct business in New York. Insurance products and related services are sold in New York by its subsidiary, First Great-West Life & Annuity Insurance Company. Other products and services may be sold in New York by FASCore, LLC.