The Housing Agency Retirement Trust 457b Deferred Compensation Plan — Enrollment Form

Plan Number: 064114 **Company Code** ________ **Social Security #:** ___ – __ – ____

Employee Name: ______________________
Last, First, Middle

Address: ______________________ ______
Street Apt. # / PO Box #

______________ ____ ________ – ____
City State Zip Code

Birth Date: ___ ___ _____ **Hire Date:** ___ ___ _____
Month Day Year Month Day Year

I. Choose your Contribution Rate (Deductions are subject to maximum deferral limits.)

- My Before-Tax Contribution Election: ___ % **OR** $ _______.00 Per Pay Period ☐ Per Month ☐ (Check One)
- My Roth After-Tax Contribution Election: ___ % **OR** $ _______.00 Per Pay Period ☐ Per Month ☐ (Check One)

For ADP Processing
DO NOT KEY IN DATA FROM THIS SECTION (SECTION I)

NOTE: Catch-up Contributions - You may be eligible to make additional pre-tax contributions if you are age 50 or older and your Plan permits catch-up contributions. If you are Interested in making these additional contributions, please contact your Plan Representative at 1-800-798-2044.

II. Make Your Investment Election Below (Enter whole %'s only. Total must equal 100%)

Investment Options	Fund ID	Ticker Symbol	Percent	Investment Options	Fund ID	Ticker Symbol	Percent
Vanguard Federal Money Market Fund – Investor	S5	VMFXX	%	Vanguard Target Retirement Fund 2050	58	VFIFX	%
Vanguard Total Bond Market Index Fund - Institutional	4L	VBTIX	%	Vanguard Target Retirement Fund 2055	79	VFFVX	%
Dodge & Cox Income Fund	Y9	DODIX	%	Vanguard Target Retirement Fund 2060	DC	VTTSX	%
Vanguard Inflation-Protected Securities Fund - Admiral	4K	VAIPX	%	PIMCO All Asset Fund - Institutional	JR	PAAIX	%
Prudential High Yield Fund - Q	TB	PHYQX	%	Vanguard 500 Index Fund - Admiral	TJ	VFIAX	%
Vanguard Target Retirement Income Fund	6U	VTINX	%	JP Morgan Disciplined Equity Fund – R6	0K	JDEUX	%
Vanguard Target Retirement Fund 2010	VP	VTENX	%	Vanguard Mid-Cap Index Fund - Admiral	7E	VIMAX	%
Vanguard Target Retirement Fund 2015	NH	VTXVX	%	Hartford MidCap Fund - Y	7X	HMDYX	%
Vanguard Target Retirement Fund 2020	0I	VTWNX	%	Vanguard Small-Cap Index Fund – Admiral	JO	VSMAX	%
Vanguard Target Retirement Fund 2025	0O	VTTVX	%	T. Rowe Price Institutional Small Cap Stock Fund	5D	TRSSX	%
Vanguard Target Retirement Fund 2030	HS	VTHRX	%	Vanguard Total International Stock Index Fund - Admiral	J0	VTIAX	%
Vanguard Target Retirement Fund 2035	W6	VTTHX	%	American Funds EuroPacific Growth Fund - R6	8G	RERGX	%
Vanguard Target Retirement Fund 2040	GI	VFORX	%	DFA Emerging Markets Portfolio - I	SI	DFEMX	%
Vanguard Target Retirement Fund 2045	D8	VTIVX	%	American Century Real Estate Fund - R6	TY	AREDX	%
Total (must equal 100%)							**100%**

☐ Automatically rebalance my entire account balance to match my most current investment allocation (Check (√) one):
☐ Quarterly (Mar, Jun, Sep, Dec) ☐ Semi-Annually (Jun, Dec) ☐ Annually (Dec)

III. Acknowledgement and Signature

I have read and understand the summary describing the Plan, have completed the Beneficiary Form and agree to be bound by the provisions of the Plan. I have also reviewed a current prospectus for each of the portfolios, and understand the objectives, risks, expenses and charges associated with each. I authorize the company to make the necessary payroll deductions from my compensation as indicated in Section I. of this form. This election will remain in effect until I elect to change or to discontinue the payroll deductions. Furthermore, I understand that if I fail to complete the investment election in Section II., I will be deemed to direct that future contributions will be invested in the plans default fund. I also understand that my deferral election will be effective as soon as reasonably possible after this form is received and processed.

______________________ ______________
Signature of Employee/Participant Date:

____
Name of Employer

______________________ ______________
Signature of Agency Authorized Official Date:

Agency keep **original**, employee keep a copy and **fax form to: 1-973-712-7489**

Housing Agency Retirement Trust, c/o ADP Retirement Services, PO Box 22669, Louisville, KY 40252-0669
PHONE: 1-800-798-2044

The Housing Agency Retirement Trust 457b Deferred Compensation Plan | Beneficiary Designation Form

Plan Number: 064114 Company Code ___________

Social Security #: ___ - __ - ____

Employee Name: ______________________
Last, First, Middle

I. Beneficiary Instructions

The Beneficiary Designation Form is used to designate the recipient of your account balance upon your death. This form must be completed by all employees when completing the Enrollment Form or Rollover Form (if not previously enrolled).

Section II. A primary beneficiary must and a secondary beneficiary may be designated.

If the primary beneficiary(ies) predeceases you, the secondary beneficiary(ies) will receive the account balance. You must attach an additional beneficiary form(s), if you elect to designate more than two primary and/or more than two secondary beneficiaries. Please ensure all primary beneficiaries' benefit percentages total 100%. Also, ensure all secondary beneficiaries' benefit percentages total 100%. Please note that a Joint Primary Beneficiary can be the same person named as the secondary beneficiary. Sign and date the form upon completion.

II. Beneficiary Designation

Primary Beneficiary

SSN: ___ - __ - ____

Name: ______________________
Last, First Middle

Address: ______________________
Street | Apt # / PO Box#

____
City, State, Zip

Relationship: ______________________

Birth Date: ______________ ______%
Month Day Year

SSN: ___ - __ - ____

Name: ______________________
Last, First Middle

Address: ______________________
Street | Apt # / PO Box#

____
City, State, Zip

Relationship: ______________________

Birth Date: ______________ ______%
Month Day Year

Contingent Beneficiary

SSN: ___ - __ - ____

Name: ______________________
Last, First Middle

Address: ______________________
Street | Apt # / PO Box#

____
City, State, Zip

Relationship: ______________________

Birth Date: ______________ ______%
Month Day Year

SSN: ___ - __ - ____

Name: ______________________
Last, First Middle

Address: ______________________
Street | Apt # / PO Box#

____
City, State, Zip

Relationship: ______________________

Birth Date: ______________ ______%
Month Day Year

If none of my designated beneficiaries are living at the time of my death, or I have not designated a beneficiary, then any distribution of my plan accounts shall be payable to a default beneficiary or beneficiaries in accordance with the terms of the plan. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If no primary beneficiary survives me, the contingent beneficiary(ies) shall acquire the designated share of my plan balance.

______________________ Date: __________
Name (please print)

______________________ Date: __________
Signature of Employee/Participant

____
Name of Employer

______________________ Date: __________
Signature of Agency Authorized Official

Agency keep **original**, employee keep a copy and **fax form to: 1-973-712-7489**

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