

HOUSING AGENCY RETIREMENT TRUST

ENROLLMENT FORM #110

PLEASE TYPE ALL INFORMATION ON THIS FORM

IMPORTANT!! Use this form only to enroll newly-eligible employees. Do not use this form to change data on existing participants.

Once you have met the eligibility provisions as stipulated in the Agency's Joinder Agreement, participation in this Retirement Plan is mandatory, a condition of employment.

REQUEST FOR MEMBERSHIP - ACCEPTANCE OF PROVISIONS - DESIGNATION OF BENEFICIARY - AUTHORIZATION OF DEDUCTIONS - INVESTMENT ELECTIONS

Plan Number:

5	9	8			
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Agency Name: _____

Name: _____
Last First Middle

Mailing Address: _____

City: _____

State: _____ Zip Code: _____

Social Security Number:

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Sex: Male Female

Date of Birth:

Month		Day				Year							

Date Hired:

Month		Day				Year							

Annual Salary: \$ _____

I hereby apply for membership in this Plan effective the first day of:

Month	Year

- I have read a summary of the plan and understand the benefits.
- I accept and agree to be bound by the provisions of the Plan and the Trust Agreement, and any amendments made to it.
- If applicable, I hereby authorize my Employer to withhold through periodic payroll deductions my required contributions to the Plan.
- I have read and understand the information provided about the 27 investment funds available.

Check One: This is the first time I have enrolled in this Plan.

I was a member previously when I worked for _____ Authority.

EMPLOYEE NAME

EMPLOYER NAME

Signed by _____

SIGNATURE OF EMPLOYEE

SIGNATURE OF AUTHORIZED OFFICIAL

Signed this _____ day of _____, 20____

Signed this _____ day of _____, 20____

INVESTMENT OF CONTRIBUTIONS

INVESTMENT FUNDS: I want the current contributions invested as follows: (Enter whole percentages – Must add up to 100%)

ALL CONTRIBUTIONS (If you make no election, all contributions will be invested in the Target Retirement Fund)

FUND MANAGER	FUND NAME	TICKER	FUND ID	ELECTION MUST EQUAL 100% ENTER WHOLE %'S ONLY
Invesco	Fixed/Stable Value Fund	N/A	H8	%
Vanguard	Total Bond Market Index Institutional	VBPIX	0J	%
Dodge & Cox	Income Fund	DODIX	0P	%
SSgA	US Inflation Protected Bond NL Series – Class C	N/A	0S	%
Vanguard	Target Retirement Income Fund	VTINX	02	%
Vanguard	Target Retirement 2015 Fund	VTXVX	04	%
Vanguard	Target Retirement 2020 Fund	VTWNX	05	%
Vanguard	Target Retirement 2025 Fund	VTTVX	06	%
Vanguard	Target Retirement 2030 Fund	VTHRX	07	%
Vanguard	Target Retirement 2035 Fund	VTTHX	0E	%
Vanguard	Target Retirement 2040 Fund	VFORX	08	%
Vanguard	Target Retirement 2045 Fund	VTIVX	09	%
Vanguard	Target Retirement 2050 Fund	VFIFX	0A	%
Vanguard	Target Retirement 2055 Fund	VFFVX	0B	%
Vanguard	Target Retirement 2060 Fund	VTTSX	0C	%
Vanguard	Target Retirement 2065 Fund	VLXVX	NY	%
PIMCO	All Asset Fund Institutional	PAAIX	0Q	%
SSgA	S&P 500 Index Fund NL Series Fund Class C	N/A	0G	%
JPMorgan	Disciplined Equity Fund R6	JDEUX	0K	%
SSgA	S&P Midcap Index NL Series Fund Class C	N/A	0V	%
Hartford	MidCap Fund HLS IA	HIMCX	0T	%
SSgA	Russell Small Cap Index NL Series Fund Class S	N/A	0U	%
T. Rowe Price	Institutional Small Cap Stock Fund	TRSSX	0L	%
Vanguard	Vanguard Total International Stock Index Fund Institutional	VTSNX	0O	%
American Funds	EuroPacific Growth Fund R6	REGGX	0M	%
American Century	REIT Real Estate Fund R6	AREDX	0N	%
			TOTAL	100 %

I elect to have my entire account automatically rebalanced: (to match **the %'s** most recently elected for the investment of my contributions).

(Use keyboard arrows to choose one): Quarterly Semi-annually Annually

I desire to make additional voluntary after-tax contributions. I understand these are entirely voluntary and are over and above any contributions required by this Plan. I may discontinue these contributions at any time. I may select a percentage of pay, or a dollar amount. If I select a percentage, my contribution will change whenever I have a salary change. If I select a dollar amount, it will remain that amount until I submit a change on Form #160. I DESIRE TO MAKE ADDITIONAL VOLUNTARY AFTER-TAX CONTRIBUTIONS OF (CHOOSE ONLY ONE): _____% OF MY SALARY ~ OR ~ \$ _____ PER MONTH. I understand these additional contributions are subject to the following maximum IRS individual limit: For calendar year 2020, the total of all contributions made to the Plan each year either by me or by my employer on my behalf cannot exceed whichever is smaller: \$56,000 or 100% of my annual salary. (The \$56,000 limit may be increased by the IRS after 2020)

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EMPLOYEE NAME

SOCIAL SECURITY NUMBER

DEPT = RKOPSHART
TASK = ENROLL

PLEASE COMPLETE PAGES 1, 2 & 3
Revised April 2020

Plan Number: 5 9 8

Social Security Number:

Employee Name: Last, First, Middle

I. Beneficiary Instructions

This Beneficiary Designation Form is used to designate the recipient of your retirement account balance, and if applicable your life insurance benefit, payable upon your death. Section II. A primary beneficiary and a contingent beneficiary may be designated. If the primary beneficiary(ies) predeceases you, the contingent beneficiary(ies) will receive the account balance. If you elect to designate more than two primary and/or more than two contingent beneficiaries, you must attach any additional beneficiary form(s). Please ensure all primary beneficiaries' benefit percentages total 100%. Also, ensure all contingent beneficiaries' benefit percentages total 100%. Please note that a Joint Primary Beneficiary can be the same person named as the contingent beneficiary. 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 retirement plan accounts shall be paid in a single sum to my estate. Sign and date the form upon completion.

II. Beneficiary Designation - Retirement Plan

Form with two columns for Primary and Contingent Beneficiaries, including fields for SSN, Name, Mailing Address, City, State, Zip, and Relationship.

III. Beneficiary Designation - Supplemental Death Benefit / Life Insurance (if applicable)

Form with two columns for Primary and Contingent Beneficiaries, including fields for SSN, Name, Mailing Address, City, State, Zip, and Relationship.

IV. I certify that this information is correct.

Signed at (City, State) this the day of Month Year

Name of Employer Signature of Agency Authorized Official (Required) Signature of Employee

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