Participant Enrollment
Governmental 457(b) Plan

City of Cambridge OBRA 457 Deferred Compensation Plan 340304-02

Participant Information

Last Name | First Name | MI

Social Security Number

Address - Number & Street

E-Mail Address

City | State | Zip Code

❑ Married ❑ Unmarried ❑ Female ❑ Male

( ) Home Phone ( ) Work Phone

Mo Day Year — Date of Birth

Mo Day Year — Date of Hire

Do you have a retirement savings account with a previous employer or an IRA? ❑ Yes or ❑ No

Statement Delivery - Participant quarterly statements are sent regular mail via the U.S. Postal Service. If you prefer an environmentally friendly alternative, please visit www.gwrs.com for fast and easy enrollment in our Online File Cabinet service.

Investment Option Information (applies to all contributions) - Please refer to your communication materials for 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.

INVESTMENT OPTION

NAME	TICKER	CODE	%
Prudential Fixed Fund	N/A	PU-FIX	____

MUST INDICATE WHOLE PERCENTAGES = 100%

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

Contingent Beneficiary

100.00%

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

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.

Last Name	First Name	MI	Social Security Number

Compliance With Plan Document and/or the Code - Participation in this Plan is mandatory. A deduction will be taken from your wages and invested on your behalf based on your employer's Plan Document. 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.

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.

Signature(s) and Consent

Participant Consent

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.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.
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 Plan Administrator/Trustee

Authorized Plan Administrator/Trustee Approval

Authorized Plan Administrator/Trustee Signature **Date**

Plan Administrator 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 #: 1-888-672-7240
Fax #: 1-866-745-5766