ACKNOWLEDGEMENT OF RECEIPT

Of

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

EMPLOYEE'S NAME (PRINT): _____

EMPLOYEE'S SCEIS NUMBER: _____

EMPLOYEE'S SIGNATURE:_____

DATE: _____

November 2014

ACKNOWLEDGEMENT OF RECEIPT

FOR

NOTICE OF HIPPA SPECIAL ENROLLMENT RIGHTS AND PRE-EXISTING CONDITION EXCLUSIONS

EMPLOYEES NAME: _____

EMPLOYEE NUMBER: _____

EMPLOYEE SIGNATURE: _____

DATE: _____

ACTIVE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

A

See Instructions - if completing by hand use black ink

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION

Select One
- ☐ New Hire/Election
- ☐ Transfer
- ☐ Change

Type of Change
- ☐ Enrollment
- Other (*specify*) _____
- Date of Change Event _____

BA Use Only
- Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)*
- Group ID #: _____ Pay periods per year: _____
- Group Name: _____

Eligible due to the Affordable Care Act: ☐ Full-time nonpermanent ☐ Variable-hour

ENROLLEE INFO

1. Social Security number or BIN	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth (MM/DD/YYYY)

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. Email Address
☐ M ☐ F	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated			

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Hire Date (MM/DD/YYYY)
						$	

COVERAGE

20. HEALTH PLAN *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Standard	☐ Employee/Spouse
☐ Savings	☐ Employee/Child(ren)
☐ TRICARE Supplement	☐ Family

21. DENTAL *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Employee
☐ Dental Plus	☐ Employee/Spouse
☐ Basic Dental	☐ Employee/Child(ren)
	☐ Family

22. DEPENDENT LIFE Child(ren) *(select one)*
- ☐ Refuse
- ☐ $15,000

23. DEPENDENT LIFE Spouse *(select one)*
- ☐ Refuse
- ☐ Total Coverage Amount $ _____

24. OPTIONAL LIFE *(select one)*
- ☐ Refuse
- ☐ Total Coverage Amount $ _____

25. SUPPLEMENTAL LTD *(select one)*
- ☐ Refuse
- ☐ Plan One - *90-day waiting period*
- ☐ Plan Two - *180-day waiting period*

26. VISION CARE *(select one)*
- ☐ Refuse
- ☐ Employee
- ☐ Employee/Spouse
- ☐ Employee/Child(ren)
- ☐ Family

MONEYPLUS ELECTIONS

27. MONEYPLUS ELECTIONS **MoneyPlus Pretax Premiums** ☐ Refuse ☐ Enroll

If you enroll in a health savings account (Section C), you cannot enroll in a medical spending account (Section A), but may enroll in a limited-use medical spending account (Section D). There is a monthly fee of $2.14 for medical spending, dependent care, and limited-use medical spending accounts. There is a monthly fee of $0.50 for health savings accounts.

A. MEDICAL SPENDING ACCOUNT

☐ New Enrollment ☐ Re-enrollment ☐ Refuse

Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is $3,200 annually.

Plan year total amount: $ _____

B. DEPENDENT CARE SPENDING ACCOUNT **(for child/adult daycare)**

☐ New Enrollment ☐ Re-enrollment ☐ Refuse

Tax filing status, please check one:
- ☐ Married, filing separately (Maximum - $2,500*) _____ Daycare costs increase/decrease
- ☐ Single, head of household (Maximum - $5,000*) _____ Dependent child turns 13
- ☐ Married, filing jointly (Maximum - $5,000*)

Plan year total amount: $ _____

**Contribution limit for highly compensated employees is $1,600.*

C. HEALTH SAVINGS ACCOUNT

☐ New Enrollment ☐ Contribution Amount Change ☐ Refuse

Select which type of State Health Plan Savings Plan coverage you have:
- ☐ Individual (Maximum - $4,150)
- ☐ Family (Maximum - $8,300)
- ☐ Over 55 Catch-up (additional $1,000)

Plan year total amount: $ _____

D. LIMITED-USE MEDICAL SPENDING ACCOUNT

☐ New Enrollment ☐ Re-enrollment ☐ Refuse

Receive reimbursement for eligible dental and vision expenses incurred by you, your family members, or both. The maximum allowable contribution is $3,200 annually.

Plan year total amount: $ _____

Qualified Change Events (Check and date all that apply) for A & B:

_____ Marriage	_____ Spouse/dependent passed away	_____ Spouse ends unpaid leave	_____ Other
_____ Newborn	_____ Employee begins unpaid leave	_____ Spouse begins unpaid leave	
_____ Adoption	_____ Employee ends unpaid leave	_____ Job change from part-time to full-time	
_____ Divorce	_____ Ineligible dependent child	_____ Job change from full-time to part-time	

EMPLOYEE INITIALS _____ **DATE** _____

Social Security number: ______________ BIN: ____________ Last Name: ______________________ First Name: ______________________

MEDICARE

28. List yourself and any other persons to be covered who are eligible for Medicare Part A and/or Part B.

Name	Medicare #	Eligible due to	Effective Date Part A (MM/DD/YYYY)	Effective Date Part B (MM/DD/YYYY)
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

BENEFICIARIES

29. In blocks 29 and 30, if there are additional beneficiaries or dependents, list on a separate sheet, signed and dated by employee.

Basic Life/Opt Life (select one or both) ☐ Basic Life ☐ Optional Life
SSN Last Name First Name Relationship Date of Birth (MM/DD/YYYY) ______________
Address ☐ Same as subscriber (Street, City, State, Zip)
Primary/Contingent (select one) ☐ Primary ☐ Contingent
Phone number Email address

Basic Life/Opt Life (select one or both) ☐ Basic Life ☐ Optional Life
SSN Last Name First Name Relationship Date of Birth (MM/DD/YYYY) ______________
Address ☐ Same as subscriber (Street, City, State, Zip)
Primary/Contingent (select one) ☐ Primary ☐ Contingent
Phone number Email address

Basic Life/Opt Life (select one or both) ☐ Basic Life ☐ Optional Life
SSN Last Name First Name Relationship Date of Birth (MM/DD/YYYY) ______________
Address ☐ Same as subscriber (Street, City, State, Zip)
Primary/Contingent (select one) ☐ Primary ☐ Contingent
Phone number Email address

If beneficiary is an estate or trust, complete the following:

Estate/Trust Address If trust, Date signed

DEPENDENTS

30. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible or Dependent Life-Child coverage, your child must be eligible according to the requirements on the instructions page for this NOE.

Add (A) or Delete (D)	Dependent SSN	Last Name	First Name	Sex	Relationship	Date of Birth (MM/DD/YYYY)	Indicate Special Status
	Spouse						Does PEBA Insurance Benefits already cover your spouse? ☐Yes ☐No
	Child						☐Incapacitated
	Child						☐Incapacitated
	Child						☐Incapacitated
	Child						☐Incapacitated

CERTIFICATION & AUTHORIZATION

31. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature ________________________________ Date ______________

32. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature ________________________ Phone ______________ Date ______________

INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, vision and Optional Life up to $50,000 are deducted on a pretax basis unless refused. Pretax MoneyPlus changes must be made during enrollment or within 31 days of a qualifying change in status event.

Blocks 1-19: ENROLLEE INFORMATION: Must be completed for all transactions, including a refusal of coverage.

COVERAGE: Alterations (such as mark-throughs or white out) in this section are not allowed. To enroll, select the coverage and select the coverage level, if applicable. To refuse or cancel coverage, select Refuse.

Block 20: HEALTH: Before making a health plan selection, refer to the plan descriptions provided by your employer.

If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can enroll yourself and/or your dependent(s) only during an open enrollment period or within 31 days of a special eligibility situation.

If health coverage is refused, benefits for Basic Life and Basic Long Term Disability are forfeited. To select a health plan, check only one block under Health Plan and check only one block under Coverage Level. For dependent(s) to be covered, they must be listed in **Block 30**, and the appropriate level of coverage must be selected.

Block 21: DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in **Block 30**, and the appropriate level of coverage must be selected.

Block 22: DEPENDENT LIFE - CHILD(REN): For child(ren) to be covered for Dependent Life Insurance, they must be listed in **Block 30.** To be eligible, they must be unmarried; must be supported by you; must not be employed on a full-time basis; and must not be in the military. In addition, for a child age 19-24 to be eligible the child must be certified by the PEBA as incapacitated at the time of enrollment or must be a full-time student at an accredited school, college or university. Children older than 24 must be certified by PEBA as incapacitated to be enrolled in Dependent Life-Child. Proof of eligibility, at the time of enrollment and at the time of the claim, will be required before any benefit will be paid.

Block 23: DEPENDENT LIFE - SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total amount of coverage for your spouse, not to exceed 50 percent of your current level of Optional Life, or $100,000. Approved medical evidence of good health is required if coverage exceeds $20,000. For your spouse to be covered, he must be listed in **Block 30**.

Block 24: OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total amount of coverage. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus Pretax Premium Feature, you must wait until the next enrollment period or within 31 days of a special eligibility situation.

Block 25: SUPPLEMENTAL LONG TERM DISABILITY: Before making a selection, refer to the detailed instructions provided by your employer. Check only one block. If changing from Plan Two to Plan One, medical evidence of good health must be provided.

Block 26: VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 27: MONEYPLUS ELECTIONS**:** To enroll in a **Medical Spending Account**, complete **Section A**. To enroll in a **Dependent Care Spending Account**, complete **Section B**. Complete **Section C** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA. Refer to your *Tax-Favored Accounts Guide* for more information.) If you would also like to enroll in a **limited-used Medical Spending Account** for eligible dental and vision expenses, complete **Section D**.

Block 28. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

Block 29. BENEFICIARIES: List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

Block 30. DEPENDENTS: Legal documentation is required for all dependents. If you select a level of coverage that includes a spouse and/or dependent child (ren), they must be listed to be covered. A spouse can only be covered as a dependent if he is not an employee or retiree of an employer that participates in the state of South Carolina Insurance Benefits Program. If your spouse is an employee or retiree of an employer covered by PEBA insurance, check Yes. A child younger than 26 is eligible for health, dental and vision coverage. Misstatements on the NOE may result in termination of the dependent's coverage and recoupment of benefits paid on behalf of the ineligible dependent.

Block 31. CERTIFICATION AND AUTHORIZATION: Employees must initial and date the first page in the area provided. The second page of the form must be signed and dated by employee within 31 days of hire or the qualifying event. The benefits administrator must sign and date form and attach copies of all supporting documentation before submitting it to **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661.**

PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Certification Regarding Tobacco or E-cigarette Use

Check the appropriate box, sign and return to S.C. PEBA, 202 Arbor Lake Drive, Columbia, SC 29223.

Subscriber name:_____ Subscriber BIN/SSN: _____

Non-tobacco or e-cigarette user

☐ I certify that I am eligible for the non-tobacco-use premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:

- I certify that all persons covered on my health insurance coverage through PEBA (including myself and any dependents) are not currently using, and have not used, any tobacco products or electronic cigarettes in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
- I certify that if this information changes at any time in the future, while I have health insurance coverage through PEBA, I will notify PEBA of such change within 31 days through completion and resubmission of this form.
- I certify that this information is true and correct to the best of my knowledge.
- I understand that if it is determined that I (or any of my covered dependents) have used tobacco products or electronic cigarettes within the last six months or if I (or any of my covered dependents) start using tobacco products or electronic cigarettes subsequent to the date of this certification without notifying PEBA, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10 percent penalty and elimination of the user's out-of-pocket maximum for current year and subsequent year.
- I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the tobacco-use premium I have already paid.

☐ I certify that I am eligible for the non-tobacco-use premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:

- I certify that all covered individuals who use tobacco or electronic cigarettes have completed the Quit for Life® smoking cessation program.
- I certify that this information is true and correct to the best of my knowledge.
- I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the tobacco-use premium I have already paid.

Tobacco or e-cigarette user

☐ I acknowledge that I will pay the tobacco-use premium by checking this box. I declare that one or more persons covered on my health insurance coverage through PEBA uses tobacco products or electronic cigarettes in some form or that I choose not to disclose my status as it relates to tobacco or e-cigarette use. I understand that by not making an election I am choosing to pay the tobacco-use premium. Please do not send me this certification again unless upon request.

Subscriber signature: _____ Date: _____

Benefits administrator signature:_____ Date: _____

Supporting Documentation for Insurance Enrollments

Navigating your benefits

Below is a list of acceptable documentation to prove the relationship of dependents you are adding to insurance coverage. Any documentation that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator. If you mail documentation to PEBA, submit photocopies only, as PEBA cannot return mailed documentation. Do not use a highlighter on submitted documents, because highlighted items appear blacked out when they are scanned. If you do not have the required documentation, you might have to pay a fee to receive it from the governmental agency with the original. We encourage you to request your documentation as soon as possible, since this process could take several weeks, and many agencies increase fees for expedited delivery.[1]

- Marriage license or birth certificate: www.cdc.gov/nchs/w2w.htm.
- Birth certificate (for children born in South Carolina): www.scdhec.gov/VitalRecords.

Legal spouse

Marriage license or Page 1 of your latest federal tax return if filing jointly.

Former spouse

Photocopy of divorce decree ordering the subscriber to cover the former spouse.

Natural child

A copy of a long-form birth certificate[2] showing the subscriber as the parent.

Stepchild

A copy of the long-form birth certificate[1] showing the name of the natural parent, as well as proof that the natural parent and the subscriber are married (see Legal spouse requirement).

Adopted child

- A copy of the long-form birth certificate[1] showing the subscriber as the parent; or
- Court documentation verifying completed adoption; or
- A letter of placement from an adoption agency, an attorney or the S.C. Department of Social Services verifying the adoption is in progress.

Foster child

A court order or other legal document placing the child with the subscriber, who is a licensed foster parent.

Other children

For all other children for whom a subscriber has legal custody, a court order or other legal document granting custody of the child to the subscriber. Documentation must verify the subscriber has guardianship responsibility for the child, not just financial responsibility.

Incapacitated child

Incapacitated Child Certification form plus proof of relationship. See the appropriate child type (natural, step, adopted, foster or other) for acceptable proof of relationship.

1 In some cases, you might not have the appropriate documentation before the enrollment deadline. If the deadline to enroll is nearing, submit the election of benefits without the documentation before the deadline, and then submit the documentation as soon as it is available.
2 A short-form birth certificate does not include the parents' names and will not be accepted. Your local S.C. Department of Health and Environmental Control office issues long forms. Visit www.scdhec.gov/VitalRecords for more information. If your child was born outside of South Carolina, go to www.cdc.gov/nchs/w2w.htm for a list of vital statistics agencies in other U.S. states and territories.

PEBA SC Retirement Systems and State Health Plan

SCPEBA 122023 | Expires 12312024
Data classification: public information

Form 1100
Revised 7/1/2023
Page 1

RETIREMENT PLAN ENROLLMENT

S.C. Public Employee Benefit Authority
Retirement Benefits
Attention: Enrollment
202 Arbor Lake Drive
Columbia, SC 29223

Print or type in black ink.
Please read the instructions on Page 2 before completing this form.

ACTION REQUESTED (Check One):

- ☐ NEW ENROLLEE (First-time membership)
- ☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
- ☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
- ☐ CHANGE OF INFORMATION
  - ☐ Name (Prior name): _____
    (ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE)
  - ☐ Address
  - ☐ SSN (Old number): _____
  - ☐ Date of Birth

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix	2. First/ Middle Name	3. Social Security Number (attach copy of Social Security card only if changing SSN)	
4. Address	5. City	6. State	7. ZIP+4

8. Gender (M - Male, F - Female)	9. Date of Birth	10. Telephone Number	11. Email Address

12. Have you ever been a member of PEBA's retirement systems? ☐ No ☐ Yes

13. If item 12 is "Yes," indicate the name(s) of your former employer: _____

Did you withdraw your contributions? ☐ No ☐ Yes

14. Do you currently have a pending refund request? ☐ No ☐ Yes

15. Are you now receiving or have you applied to receive a monthly benefit from any of PEBA's retirement systems? ☐ No ☐ Yes ☐ Application in Process

16. Retirement Plan Election (CHOOSE ONE)
- ☐ SCRS ☐ PORS (See instructions) ☐ State ORP (If selected, complete item 17.)
- ☐ JSRS (Judge, Solicitor, Circuit Public Defender, or Administrative Law Court)

17. Select State ORP Service Provider
- ☐ Corebridge Financial ☐ TIAA
- ☐ Empower ☐ Voya

18. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), or individuals first elected to the S.C. General Assembly in and after November 2012, may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State Optional Retirement Program (State ORP). The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until PEBA and/or my selected State ORP service provider receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 16 above.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee's Signature _____ Date _____ Witness _____
(Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

19. Employer Code	20. Employer Name	21. Please indicate if you are the employee's primary or secondary employer. ☐ Primary Employer ☐ Secondary Employer

22. Original Date of Hire with Employer listed in Items 19-20	23. Date of Membership	24. Employee's Position Title	25. Employee's Annual Salary

26. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.

Employer Signature _____ Date _____

Work Telephone _____

Please contact PEBA's Customer Service with any questions at 803.737.6800 or 888.260.9430, or www.peba.sc.gov.

INSTRUCTIONS
(PLEASE READ BEFORE COMPLETING AND SIGNING THIS FORM)

Complete this form: to enroll a new member; to change a member's employer, name, address, date of birth, or Social Security number; for employees who have had a break-in-service (those who return from a leave-without-pay status of more than 13 months); or when changing from one retirement system to another, regardless of prior membership.

ACTION REQUESTED - (CHECK APPROPRIATE BOX) (THE EMPLOYER MAKES THESE SELECTIONS.)

NEW ENROLLEE: Enrolling in the Retirement Systems for the first time.

OPEN ENROLLMENT: Irrevocable election from State ORP - Employee previously participated in State ORP, but is now irrevocably electing membership in SCRS during open enrollment period, after the first anniversary but before the fifth annual anniversary of the person's initial enrollment in State ORP.

CHANGE OF EMPLOYER/Dual employment: A member of the Retirement Systems transferring or accepting a position with another employer or a new hire with funds on deposit in the Retirement Systems.

CHANGE OF INFORMATION: Changing any of the listed information and to request that the Retirement Systems update its records on the employee accordingly.

Name (Prior Name): Attach a copy of the marriage license or other legal document authorizing the name change. Indicate the employee's **old name** in the space provided and list his **new name** in items 1-3 in Section I.

Address: List employee's new address (items 4-7 in Section I).

SSN (Old Number): Change/correct an employee's Social Security number by listing **old Social Security number** in the space provided and completing items 1-3 in Section I. (The employee's **new Social Security number** should be listed in item 3 in Section I). Include a copy of Social Security card with correct SSN.

Date of Birth: Change an employee's date of birth by completing items 1-9 in Section I.

SECTION I - ITEMS 1-18 INSTRUCTIONS (THE EMPLOYEE COMPLETES AND SIGNS THIS SECTION.)

Items 1 - 11: Complete items 1-11 by providing the requested information.

Item 12: Indicate if you have prior membership in any of the five retirement plans (SCRS, State ORP, PORS, GARS, or JSRS).

Item 13: If item 12 is "yes," provide the name(s) of the employer(s) for whom you worked and through which you contributed to one of PEBA's retirement systems or State ORP, and indicate whether or not you received a refund of your contributions.

Item 14: Indicate whether or not you currently have a pending refund request.

Item 15: Indicate whether or not you are receiving or have applied to receive a monthly benefit from the PEBA.

Item 16: Select the retirement plan of your choice (check appropriate box). You must be eligible for membership in the retirement plan you select. To be eligible for PORS membership, an employee must be required by the terms of his employment, by election or appointment, to preserve public order, protect life and property, and detect crimes in the state; to prevent and control property destruction by fire; be a coroner in a full-time permanent position; or be a peace officer employed by the Department of Corrections, the Department of Juvenile Justice, or the Department of Mental Health. Probate judges and coroners may elect membership in PORS. Magistrates are required to participate in PORS for service as a magistrate. PORS members, other than magistrates and probate judges, must also earn at least $2,000 per year and devote at least 1,600 hours per year to this work, unless exempted by statute. By signing this form as an employer, you are certifying that the employee meets these eligibility requirements. GARS is closed to members of the General Assembly who were first elected to serve in and after November 2012; however, these members may elect to join SCRS, State ORP, or non-membership.

Item 17: If you elected State ORP, you must check the appropriate box to indicate your service provider selection.

Item 18: Please sign and date the form after you have completed items 1-17.

Your employer will complete the remainder of the form (Section II).

SECTION II - ITEMS 19-25 INSTRUCTIONS (THE EMPLOYER COMPLETES AND SIGNS THIS SECTION.)

Items 19-20: Indicate the five-digit employer code assigned to your organization by PEBA and list the name of your organization.

Item 21: Indicate if this will be the employee's primary or secondary employer.

Item 22: List the date the employee was originally hired by the current employer.

Item 23: List the date the employee will begin making contributions to his chosen retirement plan through the current employer. If an employee is electing irrevocable membership in SCRS during the State ORP open enrollment period, the effective date must be April 1 of the current year.

Item 24: Indicate the employee's position title.

Item 25: List the employee's annual salary. If the employee is part-time, the salary may be listed as an hourly wage.

Item 26: Please sign and date the form, and provide your work telephone number so that the Enrollment staff may contact you if necessary.

Form 1102
Revised 11/1/2017
Page 1

Print or type in black ink

Please read the instructions on the reverse (Page 2) before completing this form.

ACTIVE MEMBER BENEFICIARY FORM

BENEFICIARY DESIGNATION, CONTINGENT BENEFICIARY FOR ACTIVE MEMBERS ONLY- RETIREES USE FORM 7201

SC Public Employee Benefit Authority
202 Arbor Lake Drive
Columbia, SC 29223

Use for designation of active member beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:

☐ New Enrollee

☐ Change of Beneficiary

Retirement System (check one)

☐ SCRS ☐ PORS

☐ GARS ☐ JSRS

Section I **PERSONAL INFORMATION**

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number

4. Date of Birth	5. Address

6. City	7. State	8. ZIP+4

ALL SECTIONS MUST BE COMPLETED

Section II-A* BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS - I designate the following **PRIMARY** beneficiary(ies) to receive my Retirement Systems refund of contributions or survivor benefits if eligible.

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section II-B* Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died - I designate the following **CONTINGENT** beneficiary(ies) to receive my Retirement Systems refund of contributions or applicable survivor benefits. **If the contingent beneficiary designation below is blank all previous contingent beneficiaries will be revoked and your estate will become your contingent beneficiary.**

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III* **BENEFICIARY(IES) FOR INCIDENTAL DEATH BENEFIT (You may not designate contingent beneficiaries for the Incidental Death Benefit). I designate the following beneficiary(ies) to receive my Retirement Systems Incidental Death Benefit:**

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

*** YOUR BENEFICIARY DESIGNATIONS WILL NOT BE REVOKED UNDER SECTION 62-2-507 OF THE SOUTH CAROLINA CODE OF LAWS BY DIVORCE, ANNULMENT, OR ORDER TERMINATING MARITAL PROPERTY RIGHTS.**

Section IV **CERTIFICATION AND CONDITIONS**

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (Page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (Page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

INSTRUCTIONS

USE THIS FORM FOR ACTIVE MEMBER BENEFICIARY DESIGNATIONS WHICH DO NOT REQUIRE A TRUSTEE APPOINTMENT. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME. AN ACKNOWLEDGMENT LETTER WILL BE SENT TO THE MEMBER EACH TIME A FORM IS RECEIVED BY THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY (PEBA). FOR RETIREE BENEFICIARY DESIGNATION, USE FORM 7201.

Check the appropriate boxes in the upper right corner. If you are a member of more than one system, complete a beneficiary form (FORM 1102) for each system. You should complete a form for each system of which you are a member when making any beneficiary changes (i.e. if you complete a FORM 1102 for your SCRS account, beneficiary changes will be for that system only, your prior designations for your PORS account would still be in effect).

SECTION I

1-8. Complete the general information concerning yourself.

SECTION II-A REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS

On this form you may designate a person(s) or your estate as beneficiary for your retirement contributions or survivor benefits. Leave the relationship, sex, date of birth, and SSN blank if you are naming your estate as beneficiary. If you are naming your estate as beneficiary, you may not designate a person(s) for this portion of your retirement benefits. If additional space is needed to designate more than three beneficiaries, complete and attach a second Form 1102 and indicate on the form how many pages are being submitted. That information will assist the PEBA in determining total number of forms submitted in the event the forms are separated during the processing. **If Section II-A is left blank the Form 1102 is incomplete. The Form 1102 is marked "VOID" and returned for completion of a new form.**

NOTE: SURVIVOR BENEFITS WILL NOT BE PAID TO AN ESTATE - LUMP SUM REFUND ONLY!

SECTION II-B CONTINGENT BENEFICIARY (OPTIONAL)

In accordance with §9-1-1650, §9-9-100, and §9-11-110, Code of Laws of SC (1976) as amended, an "active" member (a member who is actively employed, making regular contributions and earning service credit) may name contingent beneficiaries to receive a refund of member contributions or survivor benefits (if eligible). **{THESE CONTINGENT BENEFICIARIES HAVE NO RIGHTS, UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED}**. Contingent beneficiaries may not be designated for Incidental Death Benefit. If you do not want a contingent beneficiary, write "NONE" in Section II-B on the reverse (Page 1) of this form. **If a form is received in which the contingent beneficiary section is left blank, the designation will default to estate, even if there is a prior contingent beneficiary designation on file**.

SECTION III INCIDENTAL DEATH BENEFIT

You may name different beneficiaries for the Incidental Death Benefit (a benefit equal to your annual salary), paid in a lump sum (if the employer has elected this coverage). The $3,000 State Life Insurance and Optional Life Insurance are administered by the Employee Insurance Program (EIP); contact EIP for information pertaining to those benefits. Contact your employer or PEBA for Incidental Death Benefit coverage. If you do not have Incidental Death Benefit coverage, write "N/A" in Section III on the reverse (Page 1) of this form.

SECTION IV CERTIFICATION AND CONDITIONS

1. **CERTIFICATION:** This form must be signed by the member in the presence of a notary public and be properly notarized. If more than one form is completed, **ALL** forms must be notarized on the same date. **FORMS ALTERED IN THE BENEFICIARY DESIGNATION OR CERTIFICATION SECTIONS WILL NOT BE ACCEPTED.**
2. **REVOCATION:** All previous beneficiary designations to receive retirement benefits are hereby revoked.
3. **AUTHORIZATION:** I hereby authorize PEBA to make payment of any refund of my accumulated contributions and/or any other payment due in the event of my death prior to retirement to the beneficiary(ies) designated on the front of this form (Page 1) in accordance with the provisions of PEBA, and agree on behalf of myself and my heirs and assigns, that any payment so made shall be a complete discharge of the claim or claims, and shall constitute a release of PEBA from any further obligations on account of the benefit or benefits. In the event my primary beneficiary(ies) predeceases me and if a contingent beneficiary designation is on file, PEBA would pay any benefits due to the contingent beneficiary(ies). In the event that no primary beneficiary(ies) or contingent beneficiary(ies) are alive at the time of my death, my estate (which is ineligible for survivor benefits), will automatically become my designated beneficiary. I reserve the right to change the designated beneficiary(ies) by a written designation filed with PEBA in accordance with its rules and regulations.
4. **PAYMENT:** PEBA shall be fully discharged of liability for all amounts paid to the beneficiary(ies), and shall have no other obligation as to the application of such amounts. In any dealing with a beneficiary(ies), including but not limited to any consent, release, or waiver of interest, PEBA shall be fully protected against the claim or claims of every other person.
5. **MULTIPLE BENEFICIARIES:** Survivor benefits payable to two or more beneficiaries shall be calculated based upon the average age of the designated beneficiaries. Payments will be equally divided among surviving beneficiaries at the member's death.

Form 1106
Revised 11/1/2017

STATE ORP ACTIVE INCIDENTAL DEATH BENEFIT BENEFICIARY DESIGNATION

SC Public Employee Benefit Authority
Attention: Enrollment
202 Arbor Lake Drive
Columbia, SC 29223

Print or type in black ink

Please read the instructions on Page 2 before completing this form.

CHECK ONE:
☐ State ORP New Enrollee
☐ State ORP Active Incidental Death Benefit Beneficiary Change

Section I* **PERSONAL INFORMATION**

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number

4. Date of Birth	5. Address

6. City	7. State	8. ZIP+4

Section II* **BENEFICIARY(IES) FOR ACTIVE INCIDENTAL DEATH BENEFIT**
I designate the following beneficiary(ies) to receive the State ORP Incidental Death Benefit:

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
4. Name of Trustee(s)	Trust ID, if applicable	Address of Trustee(s)		
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
Name of Trust Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

*** YOUR BENEFICIARY DESIGNATIONS WILL NOT BE REVOKED UNDER SECTION 62-2-507 OF THE SOUTH CAROLINA CODE OF LAWS BY DIVORCE, ANNULMENT, OR ORDER TERMINATING MARITAL PROPERTY RIGHTS.**

Section III **CERTIFICATION AND CONDITIONS**

IMPORTANT:
Please read the Certification and Conditions section of the instructions on Page 2 before signing this form. I hereby certify I have read and understand the information on Page 2, including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ WITNESS _____
(Do not print) (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

ACKNOWLEDGED BEFORE ME THIS DATE_____ NOTARY NAME _____

MY COMMISSION EXPIRES_____ NOTARY SIGNATURE _____
(Out of state, requires Seal)

PAGE ____ OF ____

Please contact PEBA's Customer Contact Center with any questions at 803.737.6800 or 888.260.9430, or www.peba.sc.gov.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Form 1103
Revised 11/1/2017
Page 1
Print or type in black ink

BENEFICIARY/TRUSTEE DESIGNATION FORM

SC Public Employee Benefit Authority
202 Arbor Lake Drive
Columbia, SC 29223

Please read the instructions on the reverse (page 2) before completing this form.

Use for designation of beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:
☐ New Enrollee ☐ Change of Beneficiary

Retirement System (check one)
☐ SCRS ☐ PORS ☐ GARS ☐ JSRS

Section I **PERSONAL INFORMATION**

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number

4. Date of Birth	5. Address

6. City	7. State	8. ZIP+4

ALL SECTIONS MUST BE COMPLETED

Section II-A* **BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS**
I designate the following primary beneficiary(ies) to receive my Retirement Systems refund of contributions or survivor benefits:

1. I certify that I desire to designate my Trust to receive my Retirement Systems benefits. The name of my Trust (already in existence) is _____ Dated _____

I certify that the following person will serve as the Trustee of my Trust after my death: _____

Address of Trustee(s) _____

☐ My Trust Beneficiary(ies) is a live person. I understand that in order for a survivor benefit to be paid, I or my Trustee(s) will be required to provide the excerpt of the Trust document reflecting all of the Trust beneficiaries. Otherwise, only a lump sum benefit will be paid.

☐ My Trust Beneficiary(ies) is not a live person. I understand that only a lump sum benefit will be paid.

2. Name of Beneficiary (ONE PERSON) (without a trust)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section II-B* **Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died**
I designate the following contingent beneficiary(ies) to receive my Retirement Systems refund of contributions or survivor benefits:

1. I certify that I desire to designate my Trust to receive my Retirement Systems benefits. The name of my Trust (already in existence) is _____ Dated _____

I certify that the following person will serve as the Trustee of my Trust after my death: _____

Address of Trustee(s) _____

☐ My Trust Beneficiary(ies) is a live person. I understand that in order for a survivor benefit to be paid, I or my Trustee(s) will be required to provide the excerpt of the Trust document reflecting all of the Trust beneficiaries. Otherwise, only a lump sum benefit will be paid.

☐ My Trust Beneficiary(ies) is not a live person. I understand that only a lump sum benefit will be paid.

2. Name of Beneficiary (ONE PERSON) (without a trust)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III* **BENEFICIARY(IES) FOR INCIDENTAL DEATH BENEFIT (You may not designate contingent beneficiaries for Incidental Death Benefit.)**
I designate the following beneficiary(ies) to receive my Retirement Systems Incidental Death Benefit:

1. I certify that I desire to designate my Trust to receive my Retirement Systems benefits. The name of my Trust (already in existence) is _____ Dated _____

I certify that the following person will serve as the Trustee of my Trust after my death: _____

Address of Trustee(s) _____

☐ My Trust Beneficiary(ies) is a live person. I understand that in order for a survivor benefit to be paid, I or my Trustee(s) will be required to provide the excerpt of the Trust document reflecting all of the Trust beneficiaries. Otherwise, only a lump sum benefit will be paid.

☐ My Trust Beneficiary(ies) is not a live person. I understand that only a lump sum benefit will be paid.

2. Name of Beneficiary (ONE PERSON) (without a trust)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

*** YOUR BENEFICIARY DESIGNATIONS WILL NOT BE REVOKED UNDER SECTION 62-2-507 OF THE SOUTH CAROLINA CODE OF LAWS BY DIVORCE, ANNULMENT, OR ORDER TERMINATING MARITAL PROPERTY RIGHTS.**

Section IV **CERTIFICATION AND CONDITIONS**

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (Page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (Page 2), including the certification and conditions, and I agree to the provisions stated.

Member's Signature _____ (Do not print) Witness _____ (Required only when signed by mark)

State of _____ County of _____

Acknowledged before me this date _____ Notary Name _____

My Commission Expires _____ Notary Signature _____ (Out of state, requires Seal)

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Please contact PEBA's Customer Contact Center with any questions at 803.737.6800 or 888.260.9430, or www.peba.sc.gov.

INSTRUCTIONS

USE THIS FORM 1103 FOR ANY BENEFICIARY DESIGNATIONS THAT REQUIRE A TRUSTEE APPOINTMENT. ANY ADDITIONAL BENEFICIARY(IES), NOT REQUIRING A TRUSTEE APPOINTMENT MUST ALSO BE INCLUDED ON THIS FORM 1103.
CAUTION: IF YOUR BENEFICIARY(IES) DOES NOT REQUIRE A TRUSTEE APPOINTMENT, DO NOT USE THIS FORM 1103. THE CORRECT FORM TO USE IS THE FORM 1102.
NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME IT IS SUBMITTED. AN ACKNOWLEDGMENT LETTER WILL BE SENT TO THE MEMBER EACH TIME A FORM IS RECEIVED BY THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY (PEBA).
Check the appropriate boxes in the upper right corner. If you are a member of more than one system, complete a FORM 1103 for each system. You should complete a form for each system of which you are a member when making any beneficiary changes (i.e. if you complete a FORM 1103 for your SCRS account, beneficiary changes will be for that system only; your prior designations for your PORS account would still be in effect).

SECTION I

1-8. Complete the general information concerning yourself.

SECTION II-A: REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS

Please indicate the name of trust (must be an already established trust), date of trust, as well as the name and address of the trustee. Then check the appropriate block indicating whether or not the trust beneficiary is a live person as opposed to an artificial entity. **PLEASE NOTE: IF THE TRUST BENEFICIARY IS NOT A LIVE PERSON, THEN ONLY A LUMP SUM REFUND WILL BE PAYABLE!** If you wish to designate a beneficiary that will not be covered by the trust, then complete the information requested in block 2 of section II-A. If additional space is needed to designate more than two non-trust beneficiaries, complete and attach another FORM 1103 and indicate on the form how many pages are being submitted. That information will assist PEBA in determining the total number of forms submitted in the event the forms are separated during processing. Information concerning the SSN, sex, date of birth and relationship are applicable to the beneficiary and the member, NOT the trustee and the member.
NOTE: SURVIVOR BENEFITS WILL NOT BE PAID TO AN ESTATE OR AN ARTIFICIAL BEING - LUMP SUM REFUND ONLY!

SECTION II-B: CONTINGENT BENEFICIARY (OPTIONAL)

In accordance with §9-1-1650, §9-9-100, and §9-11-110, Code of Laws of SC (1976) as amended, an "active" member (a member who is actively employed, making regular contributions and earning service credit) may name contingent beneficiaries to receive a refund of the member contributions or survivor benefits (if eligible). (**THESE CONTINGENT BENEFICIARIES HAVE NO RIGHTS, UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED).** Contingent beneficiaries may not be designated for Incidental Death Benefit. If you wish to make a trust designation for your contingent beneficiary(ies), please complete section II-B (1) using the same instructions as for II-A (1) above. If you wish to name a contingent benneficiary not covered by a trust, complete section II-b (2). If you do not wish to designate any contingent beneficiaries, write "NONE" in Section II-B on the reverse (Page 1) of this form.

SECTION III: INCIDENTAL DEATH BENEFIT

You may name different beneficiaries for the Incidental Death Benefit (a benefit equal to your annual salary), which is paid in a lump sum (if the employer has elected this coverage). The $3,000 State Life Insurance and Optional Life Insurance are administered by the Employee Insurance Program (EIP); contact EIP for information pertaining to those benefits. Contact your employer or PEBA for Incidentatl Death Benefit information. If you wish to make a trust designation for your Incidental Death Benefit, please complete section III (1) using the same instructions as for II-A (1) above. If you wish to name an Incidental Death Benefit beneficiary not covered by a trust,complete section III (2). If you do not have Incidental Death Benefit coverage, write "N/A" in Section III on the reverse (Page 1) of this form.

CERTIFICATION AND CONDITIONS

1. **CERTIFICATION:** This form must be signed by the member in the presence of a notary public and be properly notarized. If more than one form is completed, ALL forms must be notarized on the same date. **FORMS ALTERED IN THE BENEFICIARY DESIGNATION OR CERTIFICATION SECTIONS WILL NOT BE ACCEPTED.**
2. **REVOCATION:** Previous beneficiary and trustee designations are hereby revoked.
3. **AUTHORIZATION:** I hereby authorize PEBA to make payment of any refund of my accumulated contributions and/or any other payment due in the event of my death prior to retirement to the trustee(s) and beneficiary(ies) designated on the front of this form (Page 1) in accordance with the provisions of the PEBA, and agree on behalf of myself and my heirs and assigns, that any payment so made shall be a complete discharge of the claims or claims, and shall constitute a release of the PEBA from any further obligations on account of the benefit or benefits. In the event PEBA receives satisfactory proof that the trust(s) has been revoked or is otherwise not in effect at the time of my death, any refund of contributions or any survivor benefits shall be paid directly to the beneficiary(ies) designated on this form.
   In the event my named primary beneficiary(ies) predeceases me and if a contingent beneficiary(ies) designation is on file, PEBA would pay any benefits due to the contingent beneficiary(ies). In the event that no primary beneficiary(ies) or contingent beneficiary(ies) are alive at the time of my death, my estate (which is ineligible for survivor benefits), will automatically become my designated beneficiary. I reserve the right to change the designated beneficiary(ies) by a written designation filed with PEBA in accordance with its rules and regulations.
4. **PAYMENT:** PEBA shall be fully discharged of liability for all amounts paid to trustee(s) or beneficiary(ies), and shall have no other obligation as to the application of such amounts. In dealing with a trustee(s), including but not limited to any consent, release, or waiver of interest, the PEBA shall be fully protected against the claim or claims of every other person. It shall not be charged with notice of a change of trustee(s), unless **WRITTEN** evidence of the change is received by the PEBA before or at the time a trustee(s) becomes entitled to payment. PEBA shall not be bound by the terms of any trust or any trust agreement or instrument, and PEBA shall not be liable for the application of the proceeds of retirement benefits by trustee(s) or any other person.
5. **MULTIPLE TRUST BENEFICIARIES:** Survivor benefits payable to the trustee(s) on the behalf of two or more beneficiaries of the trust shall be calculated based on the average age of the beneficiaries on Page 1 of this form. Payments will be equally divided among surviving beneficiaries at the member's death.

PEBA
SC Retirement Systems and State Health Plan
Deferred Compensation Program

Participant Enrollment/Employer Transfer

State of South Carolina Salary Deferral 401(k) Plan and Trust ❑ 98955-01 [401(k)]

State of South Carolina 457 Deferred Compensation Plan and Trust ❑ 98955-02 [457(b)]

Participant Information

Last Name | First Name | MI

(The name provided MUST match the name on file with Service Provider.)

Social Security Number

Mailing Address

E-Mail Address

City | State | Zip Code

❑ Married ❑ Unmarried

❑ Female ❑ Male ❑ Nonbinary ❑ Unspecified

( ) Home Phone

( ) Work Phone

Mo Day Year
Date of Birth

Mo Day Year
Date of Hire

( ) Mobile Phone

Annual Income

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

Would you like help consolidating your other retirement accounts into your Deferred Compensation Program (Deferred Comp) account?*
❑ Yes, I would like a representative to call me at phone #_____-_____-_____to review my options and assist me with the process. The best time to call is_____to_____A.M./P.M. (circle one - available 8:00 A.M. to 6:00 P.M. MST). *Rollovers are subject to your Plan's provisions.

❑ New Participant Enrollment - Complete all sections of this form.

❑ Employer Transfer - Complete all sections of this form if you have an active Deferred Comp account from prior covered employment. Any elections made on this form will supersede your current elections. If you elect investment options below, this election will only apply to your future contributions. If you are already enrolled in My Total Retirement, any elections made in the Investment Direction section below will be disregarded.

Participating Employer Name (Required)

Payroll Center Number (If unknown, contact your Employer.)

Payroll Deduction

Please take note of this important information before completing your contribution election(s):

- Verify with your employer that the percent (%) option is available. If not, you may only choose a flat dollar ($) amount.
- The contribution method must be the same when choosing both pre-tax and Roth within the 401(k) or 457.
- If selecting the percent (%) option, use whole percentages only.

401(k) Plan

❑ **Pre-tax** I elect to contribute $_____ or _____% (per pay period) of my compensation as before-tax contribution to the 401(k) plan until such time I revoke or amend my election.

❑ **Roth** I elect to contribute $_____ or _____% (per pay period) of my compensation after-tax as a designated Roth contribution to the 401(k) plan until such time I revoke or amend my election.

Last Name | First Name | M.I. | Social Security Number | Number

457(b) Plan

❑ **Pre-tax** I elect to contribute $_____ or _____% (per pay period) of my compensation as before-tax contribution to the 457(b) plan until such time I revoke or amend my election. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

❑ **Roth** I elect to contribute $_____ or _____% (per pay period) of my compensation after-tax as a designated Roth contribution to the 457(b) plan until such time I revoke or amend my election. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Select My Own Investment Options:

❑ I elect to direct my own investments.

I understand and agree that my employer and other plan fiduciaries will not be liable for the results of my personal investment decisions. I understand I must indicate whole percentages and that my total allocated among the funds listed below cannot excess 100%.

OR

My Total Retirement Information

The My Total Retirement provided by Empower Advisory Group, LLC will automatically direct your investment elections and will rebalance your account periodically, as necessary. This election will be effective as soon as administratively feasible following receipt of your completed enrollment form and signed Advisory Services Agreement. By electing My Total Retirement, you agree to the fees associated with this service and understand the fees will be deducted from your account in accordance with the attached Advisory Services Agreement. If you prefer to make your own investment decisions and not participate in this service, simply select the Select My Own Investment Options box and enter your investment instructions in the Investment Option Information section.

My Total Retirement:

❑ By checking this box, I elect to have my account professionally managed by Empower Advisory Group, LLC until such time as I cancel my enrollment in the service.

Make your investment election for future deposits in the Investment Option Information section.

Do not complete this section if you are electing to enroll in the My Total Retirement.

Investment Option Information (applies to all contributions) - Please refer to the Deferred Comp website www.southcarolinadcp.com Investing/Investment Information 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	INVESTMENT OPTION CODE (Internal Use Only)	
FIXED		
South Carolina Stable Value Fund	**SCSVF**	_____%
BOND		
Fidelity Inflation-Prot Bd Idx	**FIPDX**	_____%
Baird Aggregate Bond Inst	**BAGIX**	_____%
LARGE CAP		
Dodge & Cox Stock X	**DOXGX**	_____%
T. Rowe Price Growth Stock	**PRGFX**	_____%
Vanguard Institutional Index Instl Pl	**VIIIX**	_____%
MID CAP		
MFS Mid Cap Growth R6	**OTCKX**	_____%
T. Rowe Price Mid-Cap Value I	**TRMIX**	_____%
Vanguard Mid Cap Index InstlPlus	**VMCPX**	_____%
SMALL CAP		
AB Small Cap Growth I	**OUAIX**	_____%
American Beacon Small Cap Value R6	**AASRX**	_____%
TIAA-CREF Small-Cap Blend Inx Inst	**TISBX**	_____%
INTERNATIONAL		
American Funds EuroPacific Gr R6	**RERGX**	_____%
American Funds New Perspective R6	**RNPGX**	_____%
Fidelity Div Inst Comm Pool C	**FIDCMC**	_____%

ASSET ALLOCATION

Target date funds are diversified funds that automatically adjust their asset allocations over time becoming more conservative as the target retirement date approaches. Consider choosing the one fund that is closest to the date you think you will retire.

State St Target Ret 2065 SL Cl V	**S2065V**	_____%
State St Target Ret Income SL Cl V	**SRINCV**	_____%
State St Target Ret 2020 SL Cl V	**S2020V**	_____%
State St Target Ret 2025 SL Cl V	**S2025V**	_____%
State St Target Ret 2030 SL Cl V	**S2030V**	_____%
State St Target Ret 2035 SL Cl V	**S2035V**	_____%
State St Target Ret 2040 SL Cl V	**S2040V**	_____%
State St Target Ret 2045 SL Cl V	**S2045V**	_____%
State St Target Ret 2050 SL Cl V	**S2050V**	_____%
State St Target Ret 2055 SL Cl V	**S2055V**	_____%
State St Target Ret 2060 SL Cl V	**S2060V**	_____%

The above investment options selected must be whole percentages and the total allocated among the funds cannot exceed 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 my beneficiary at any time. If any information request below 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 law.

#1 _____ .
% of Account Balance | Primary Beneficiary Name | Social Security Number | Date of Birth

( ) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

#2 _____ .
% of Account Balance | Primary Beneficiary Name | Social Security Number | Date of Birth

( ) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

#3 _____ .
% of Account Balance | Primary Beneficiary Name | Social Security Number | Date of Birth

( ) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

Contingent Beneficiary

#1 _____ .
% of Account Balance | Contingent Beneficiary Name | Social Security Number | Date of Birth

( ) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

#2 _____ .
% of Account Balance | Contingent Beneficiary Name | Social Security Number | Date of Birth

( ) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

#3 _____ .
% of Account Balance | Contingent Beneficiary Name | Social Security Number | Date of Birth

( ) _____
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*
❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other
❑ Domestic Partner

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 - If I elect to direct my own investments, 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 at www.southcarolinadcp.com and I understand the risks of investing.

I understand if I elect to have my account managed by Empower Advisory Group, LLC, that my entire account, including any transfers or rollovers, will be professionally managed and I have not completed the Investment Option Information section. In the event investment option information is completed, my election to have my account professionally managed will override my investment option elections. Dollar cost averaging and asset allocation are not available if my account is professionally managed. I understand that the applicable fees will be deducted from my account. In order to enroll in the My Total Retirement, I understand that I must provide my date of birth, gender, marital status, state of residence and annual income. If any of this information is not provided, I understand that I will not be enrolled in the My Total Retirement.

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/Employer Transfer 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 I must call the Voice Response System or access the Web site in order to transfer monies from the default investment option. Also, I understand all contributions received after an account is established on my behalf will be applied to the investment options I have most recently selected.

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.

My Total Retirement Fee - If you elect the My Total Retirement, a quarterly fee will be assessed. If you wish to cancel your enrollment in the future please call your Plan's Voice Response System number.

Signature and Consent

Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form including the terms of the My Total Retirement Agreement.

Participant Signature **Date**

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Return Address:
South Carolina Deferred Compensation Program
200 Arbor Lake Drive. Suite #201
Columbia, SC 29223
Fax: 803-754-7661
Phone #: 1-877-457-6263
Website: www.southcarolinadcp.com

ADVISORY SERVICES AGREEMENT

This Agreement describes the terms and conditions applicable to the investment advice and management services (each a "Service" and collectively the "Services") offered by Empower Advisory Group, LLC ("EAG") and described below. EAG is a registered investment adviser and wholly owned subsidiary of Empower Life & Annuity Insurance Company of America ("EAIC"), which provides financial services and products under the brand name "Empower". EAG offers the Services to accounts (each an "Account" and collectively the "Accounts") held by investors participating in employer-sponsored retirement plans (each a "Plan") recordkept through Empower. By using the Services, you consent to be bound by these terms and conditions.

DESCRIPTION OF SERVICES

EAG offers the following two Services to your Account: Online Advice and the Managed Account service. You may receive all or some of the Services as determined by the Plan's sponsor. If you have multiple Accounts held with Empower, you must select which of the Services you will use for each Account.

Online Advice: Online Advice offers fund-specific investment advice to users who wish to manage their own Account but receive assistance in doing so. The investments recommended by Online Advice are based on information drawn from your Account profile and from the investment options available within your Account. You decide whether to implement the advice delivered through Online Advice.

- EAG does not provide advice for, or recommend allocations of, individual stocks (including employer stock, unless your employer instructs EAG otherwise), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies, or any other investment options that do not satisfy the methodology requirements of the subadviser who provides investment methodology to EAG.
- EAG is not responsible for any delays or limitations impacting Online Advice that are attributable to restrictions imposed by a third-party investment provider of an investment option within your Account.

Managed Account service: The Managed Account service offers users an investment management service under which investment professionals will select and allocate your Account among the available investment options. You will receive a personalized investment portfolio that reflects your retirement timeframe, life stages and overall financial picture, including, but not limited to, assets held outside your Account (if you elect to provide this information), which may be taken into consideration when determining the allocation of assets in your Account. Changes that you make to your profile, such as outside assets, your intended retirement age or constraining your portfolio to a specific risk level, will generally apply to all your accounts held through Empower. Such changes may cause each managed account, whether managed by an affiliate of Empower or an unaffiliated third-party advisor, to be rebalanced and re-allocated. For taxable accounts, rebalancing or re-allocation transactions will typically have tax implications, as a result we'll send you tax forms for any capital gains and losses associated with the rebalancing activity. Generally, EAG will not provide advice for, recommend allocations of, or manage your outside accounts.

- Under the Managed Account service, EAG has discretionary authority over allocating your assets among the Plan's investment options without your prior approval of each transaction. EAG is not responsible for either the selection or maintenance of the investment options available within your Plan. Further, EAG is not responsible for any delays or limitations impacting the Managed Account service attributable to restrictions imposed by a third-party investment provider of an investment option within your Account.
- EAG does not provide advice for, or recommend allocations of, individual stocks (including employer stock, unless your employer instructs EAG otherwise), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies, or any other investment options that do not satisfy the methodology requirements of the subadviser who provides investment methodology to EAG. Your balances in any of these investment options or vehicles may be liquidated, subject to your Plan's and/or investment provider's restrictions.

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- Account assets subject to the Managed Account service will be monitored, rebalanced and reallocated periodically by EAG, according to the methodology of EAG's subadviser. You will receive an Account update statement periodically and can update your personal information at any time by calling EAG or by visiting the Plan website.

INFORMATION ABOUT PARTICIPATION IN THE SERVICES

Information Gathered to Provide the Services. You or your employer must provide all data that is necessary for EAG to perform its duties under this Agreement, including but not limited to: your date of birth, income, gender, and state of residence, which EAG may rely upon in providing the services to you. If the data supplied by you or your Plan sponsor, if applicable, does not meet the Managed Account service methodology requirements, we will attempt to contact you for updated information. If this is not completed, your enrollment in the Managed Account service may not be completed or may be terminated. Information that you provide in addition to the recordkeeping data sources, such as linking accounts manually, through account aggregation or linking multiple record-kept Employer plans through OneID/One Password in the Empower Personalized Experience, may all be used by the Services to help personalize your recommendations and projections. Please ensure manually entered assets are not already being included by the Services automatically as this may impact the recommendations and projections. If you participate in My Total Retirement, you will receive a Welcome Kit shortly after enrollment. You will also receive an account update statement periodically, providing you with a detailed analysis of your Account. Your account update statement will also confirm your personal data which is used to provide you with personalized investment management.

You are responsible for reviewing your account statements, transaction confirmations, and advisory services communications carefully for discrepancies or errors. Call your Plan's toll-free customer service number to notify EAG of any incorrect information including, but not limited to, current or future investment allocations, desired retirement age, investment risk level, and outside investment holdings.

You must notify EAG of any errors or discrepancies immediately. EAG is not responsible for corrections related to incorrect data provided by you or your Plan sponsor and is also not responsible for the correction of errors not reported in a timely manner.

Fees Applicable to the Services. Appendix A to this Agreement describes the fees applicable to the Services. You authorize EAG to deduct the billing period fee described in Appendix A. The fees are subject to change. EAG reserves the right to offer discounted fees or other promotional pricing.

Investment Methodology. EAG generates investment recommendations under Online Advice and My Total Retirement using an investment methodology generated by its independent subadviser (currently, Morningstar Investment Management LLC, herein "Morningstar"). EAG may change its subadvisor at any time. Using its proprietary methodology, Morningstar determines an appropriate asset level portfolio that best suits each user's situation using the investment options available for the Services. Your Account is monitored and rebalanced periodically among the available investment options. EAG will also provide various recommendations and projections for your Account using methodology developed by EAG or its affiliates including, but not limited to, savings rate advice and retirement income projections. The projections or other information generated by this process regarding the likelihood of various investment outcomes are hypothetical in nature, do not reflect actual investment results and are not guarantees of future results. Results may vary with each use and over time.

Additional Fees May Apply. Fees for the Services do not include the fees and expenses charged by the investment options to which your Account will be allocated. For more information about the fees assessed by investment options in your Account, including information about the options' expense ratios and share class, please review your Plan's investment option disclosure documents. Some Plan investment options may also charge redemption fees, which vary in amount and application by each applicable investment option. It is possible that transactions performed through the Services may result in the imposition of a redemption fee on one or more available investment options. Any such redemption fees are deducted from your account balance.

Conflicts of Interest. EAG has several conflicts of interest in providing services to your Account.

- Investment advice and management services. EAG's representatives may recommend that you use the Services for your Account. If you enroll in the Managed Account service, EAG will earn additional compensation, since you will pay fees to use the Service as described in Appendix A.
- Increased fee income. When you use the Services, EAG may recommend you increase contributions to the Plan, or implement other savings or investment strategies. EAG's affiliates provide a bundle of recordkeeping, trust, custody, brokerage, investment and other related services to your Plan and to related IRA products. If you pay for these services through an arrangement where our affiliates charge a direct fee, EAG's affiliates may receive additional fees for these services as a result of EAG's recommendations, because you may contribute, invest, or transact in more assets with EAG's family of companies.
- Proprietary investment funds. EAG's affiliates offer proprietary investment funds, and EAG may recommend or allocate your Account to our affiliates' proprietary investment funds, such as proprietary mutual funds and collective investment trusts. These investment funds generate additional income to EAG's family of companies. For our proprietary investment funds, fees compensate our affiliates for administering, managing, and supervising these funds.
- Proprietary insurance products. EAG's parent company, EAIC, offers proprietary insurance products for investment. EAG may recommend or allocate your Account to different types of EAIC insurance products and funding agreements. Most EAIC insurance products are annuity contracts that are structured either as a "general account" product or as a "separate account" product. If you invest in a general account product, which is an insurance product backed by the general account of an insurance company, EAG's affiliates generate revenue by retaining spread, which is the difference between actual earnings on contracts offered by the insurer, and the crediting rate declared and guaranteed by the insurer through the contract. EAG's affiliates may also receive different types of fee income if you invest in the general account or separate account products, as well as other third-party payments associated with investments held in the separate account.
- Third-Party Payments. EAG's affiliates receive payments from other firms, non-proprietary investment funds or products, or providers, such as revenue sharing payments, in connection with the investments made in your Account pursuant to our recommendation or investment management. For example, a mutual fund available through your Plan may make 12b-1 payments to EAG's affiliated broker-dealer based on your Account investment.
- Representative Compensation. EAG's representatives are generally paid a salary and a variable bonus. The bonus is based on a combination of the performance of Empower, as well as the representative's individual performance. Additionally, EAG has authorized Empower Financial Services, Inc. ("EFSI") and its licensed agents and registered representatives, to solicit, refer and market the Services to Plan sponsors and potential users. EFSI representatives may be compensated in part based on these solicitation activities, in accordance with applicable law.

For additional information about the Services, the methodology used to produce investment and other recommendations, compensation for EAG representatives or EAG's conflicts of interest, please see EAG's Form ADV and information available at www.empower.com.

Cancellation. Once enrolled in the Managed Account service, you will no longer be able to make investment allocation changes to your Account. You may cancel participation in the Managed Account service at any time online or by calling EAG. Once you have opted-out of the Managed Account service, you are responsible for managing your own Account. You will need to initiate your own allocation changes and/or transfers if you wish to change your investment allocations made by the Managed Account service.

Proxy Voting. EAG does not assume the responsibility to provide assistance or vote proxies or other issuer communications regarding your Account, or to exercise voting or other decision-making authority regarding proxies or other issuer communications. Correspondence regarding the matters described in this section will be handled in connection with the Plan's policies and service provider arrangements.

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STANDARD OF CONDUCT, LIABILITY AND INDEMNITY

EAG acknowledges that, as a registered investment adviser, it owes a fiduciary duty to customers with respect to investment advice it provides. EAG may also be a fiduciary to your Account pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), depending on whether your Plan is subject to ERISA. EAG uses reasonable care, consistent with industry practice, in providing services to you. EAG, your Plan sponsor and/or the Plan recordkeeper, as applicable, do not guarantee the future performance of your Account or that the investments we recommend will be profitable. Investment return and principal value will fluctuate with market conditions, and you may lose money. The investments EAG may recommend or purchase for your Account, if applicable, are subject to various risks, including, without limitation; business, market, currency, economic, and political risks. By recommending allocations among the available investment options, we are not endorsing the selection of particular investment options available in your Plan.

EAG, the Plan sponsor and/or the Plan recordkeeper, as applicable, will not be liable to you for any loss caused by (1) our prudent, good faith decisions or actions, (2) following your instructions, or (3) any person other than EAG or its affiliates who provides services for your Account. Neither EAG nor your Plan sponsor will be liable to you for any losses resulting from your disclosure of your personal information or your password to third parties even if the purpose of your disclosure is to enable such person to enroll you in or cancel your enrollment in the Services.

You agree to indemnify, defend and hold harmless EAG and its officers, directors, shareholders, parents, subsidiaries, affiliates, employees, consultants, agents and licensors, your employer, the Plan administrator and/or recordkeeper, Plan sponsor, Plan trustees, Plan fiduciaries, their agents, employees, and contractors, as applicable, from and against any and all third party claims, liability, damages and/or costs (including but not limited to reasonable attorneys' fees) arising from your failure to comply with this Agreement, the information you provide us, your infringement of any intellectual property or other right of a third party, or from your violation of applicable law. YOU UNDERSTAND THAT IN NO EVENT WILL THE PLAN SPONSOR, EAG OR ITS OFFICERS, DIRECTORS, SHAREHOLDERS, PARENTS, SUBSIDIARIES, AFFILIATES, EMPLOYEES, CONSULTANTS, AGENTS, LICENSORS OR ANY DATA PROVIDER BE LIABLE FOR ANY CONSEQUENTIAL, PUNITIVE, INCIDENTAL, SPECIAL OR INDIRECT DAMAGES, LOSS OF BUSINESS REVENUE OR LOST PROFITS, WHETHER IN AN ACTION UNDER CONTRACT, NEGLIGENCE OR ANY OTHER THEORY EVEN IF WE ARE ADVISED OF THE POSSIBILITY OF SUCH.

TO THE MAXIMUM EXTENT PERMITTED BY LAW, EAG DISCLAIMS ALL REPRESENTATIONS AND WARRANTIES, EXPRESS OR IMPLIED, WITH RESPECT TO THE SERVICES, AND ALL INFORMATION DERIVED FROM THEM, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, QUALITY, TIMELINESS, ACCURACY, AND IMPLIED WARRANTIES ARISING FROM COURSE OF PERFORMANCE OR COURSE OF DEALING. IN ADDITION, EAG DOES NOT WARRANT THAT THE SERVICES OR CONTENT CONTAINED IN IT WILL BE UNINTERRUPTED, ERROR FREE, FULLY AVAILABLE AT ALL TIMES OR THAT ANY INFORMATION OR OTHER MATERIAL ACCESSIBLE THROUGH THE SERVICES ARE FREE OF ERRORS OR OTHER HARMFUL CONTENT.

COMMUNICATIONS

EAG or its affiliates may provide any communications to you at your mailing address, or your e-mail address provided to us by you. You agree to not make any claims against EAG or its affiliates if you do not receive any communications sent to you. You agree to notify EAG promptly if your mailing address and/or e-mail address changes and to keep all account information, such as your mailing address and/or e-mail address, current and accurate. The website Terms of Service apply to your use of the customer website. You agree to receive electronic communications, including regulatory documents such EAG's Form ADV Part II, privacy notice and Form CRS, through the Empower website or other electronic media. EAG will not impose any additional charge to you for such electronic communication. You may opt-out of electronic communications by calling your Plan's toll-free customer service number.

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GENERAL TERMS

EAG may not assign this Agreement (within the meaning of the Investment Advisers Act of 1940 ("Advisers Act") without your consent. You may not assign this Agreement. Unless otherwise agreed to in your Plan's agreement with EAG, this Agreement is entered into in Denver, Colorado and governed by and construed in accordance with the laws of the State of Colorado, without regard to its conflict of law provisions. You agree that proper forum for any claims under this Agreement shall be in the courts of the State of Colorado for Arapahoe County or the United States District Court, District of Colorado. Please contact your Plan sponsor to determine proper venue for actions brought under this agreement. The prevailing party shall be entitled to recovery of expenses, including reasonable attorneys' fees. This Agreement constitutes the entire Agreement between you and EAG with respect to the subject matter herein. If for any reason a provision or portion of this Agreement is found to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the parties, and the remainder of this Agreement will continue in full force and effect. No failure or delay on the part of EAG in exercising any right or remedy with respect to a breach of this Agreement by you shall operate as a waiver thereof or of any prior or subsequent breach of this Agreement by you, nor shall the exercise of any such right or remedy preclude any other or future exercise thereof or exercise of any other right or remedy in connection with this Agreement. Any waiver must be in writing and signed by EAG. All terms and provisions of this Agreement will survive termination of the Agreement. This Agreement will automatically terminate upon termination of your Plan's agreement with EAG, or upon termination of your Plan's service agreement with its recordkeeper, if applicable. Nothing in this Agreement shall be construed to waive compliance with the Advisers Act, ERISA, if applicable, or any applicable rule or order of the Department of Labor under ERISA. EAG shall not be liable for any delay or failure to perform its obligations hereunder if such delay or failure is caused by an unforeseeable event beyond its reasonable control, including without limitation: act of God; fire; flood; earthquake; labor strike; sabotage; fiber cut; embargoes; power failure; lightning; suppliers failures; act or omissions of telecommunications common carriers; material shortages or unavailability or other delay in delivery; government codes, ordinances, laws, rules, regulations or restrictions; war or civil disorder, or acts of terrorism. EAG reserves the right to modify this Agreement at any time. You agree to review this Agreement periodically so that you are aware of any such modifications. Your continued participation in the Services shall be deemed to be your acceptance of the modified terms of this Agreement. This Agreement shall inure to the benefit of EAG's successor and assigns. EAG, its officers and employees may purchase securities for their own Accounts and these securities may be the same as those recommended to, or invested for, you (e.g., shares of the same mutual fund).

INTELLECTUAL PROPERTY

All content provided as part of the Services, including without limitation names, logos, methodologies, and news or information provided by third parties, is protected by copyrights, trademarks, service marks, patents, or other intellectual property and proprietary rights and laws ("Intellectual Property") and may constitute trade secrets, as defined by applicable law. All such Intellectual Property is the property of their respective owners and no rights or licenses are granted to you as a result of your participation in the Services.

ABOUT EMPOWER ADVISORY GROUP, LLC

Additional information about the services provided by EAG may be found in EAG's Form ADV Part II, which is available free of charge online at www.adviserinfo.sec.gov and www.empower.com, or upon request by calling your Plan's toll-free customer service number or by writing EAG at: 8515 East Orchard Road, Greenwood Village, Colorado 80111.

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SUPPLEMENT A

FEES FOR THE SERVICE

Fees for each service are shown below. The chart below reflects the applicable billing period and annual fee amount.

Online Advice	**Quarterly Fee**	**Annual Fee**
	$0.00	$0.00

My Total Retirement		
Participant Account Balance	**Quarterly Fee**	**Annual Fee**
≤ $100,000.00	0.1125%	0.45%
Next $150,000.00	0.0875%	0.35%
Next $150,000.00	0.0625%	0.25%
≥ $400,000.01	0.0375%	0.15%

For example, if your account balance subject to My Total Retirement is $50,000.00, the maximum annual fee is 0.45% of the account balance. If your account balance subject to My Total Retirement is $500,000.00, the first $100,000.00 will be subject to a maximum annual fee of 0.45% (quarterly 0.1125%), the next $150,000.00 will be subject to a maximum annual fee of 0.35% (quarterly 0.0875%), the next $150,000.00 will be subject to a maximum annual fee of 0.25% (quarterly 0.0625%), and any amounts over $400,000.00 will be subject to a maximum annual fee of 0.15% (quarterly 0.0375%). For example, the maximum quarterly fee for an account balance less than $100,000.00 (subject to maximum annual fee of 0.45%) would be 0.1125% quarterly, as demonstrated above.

If you cancel participation in the service, the fee will be based on your participation in the My Total Retirement through the date of cancellation for asset-based fees. For dollar-based fees, the full billing period rate will be assessed notwithstanding the date of cancellation. If your Plan terminates its agreement with its recordkeeper, the fee will be debited based on your participation in the My Total Retirement through the date of such termination.

You can access our Privacy Policy via the link below:
https://www.empower.com/privacy

You can access our ADV Disclosure Brochure via the link below:
https://dcprovider.com/EAG/EAG-ADV-Part-2A-Brochure-MIM-MAS.pdf