Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

PST DEFERRED COMPENSATION PLAN PARTICIPATION AGREEMENT

PLAN NUMBER: 666788

☐ **Initial Enrollment** ☐ **Re-enrollment**

PST PARTICIPANT INFORMATION

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name	
Mailing Address, City, State, Zip Code		**Telephone**	**Alternate Telephone**
Date of Birth	**Social Security Number**	**Department**	

IMPORTANT INFORMATION - PLEASE READ CAREFULLY!

The County has established a PST Deferred Compensation Plan for the benefit of its employees. The Plan requires that certain individuals, who are not eligible for membership in the San Bernardino County Employees' Retirement Association, shall become Participants in the Plan upon commencement of employment. This Plan has been designed to meet the requirements of an alternative plan to Social Security participation.

THE EMPLOYEE AGREES TO THE FOLLOWING:

1. The Employee shall become a participant and shall defer a percentage of their biweekly gross salary as established in the applicable employment contract, Memorandum of Understanding, or Compensation Plan to an account set up on their behalf in the PST Deferred Compensation Plan.
2. The employee contribution to the Plan shall not be less than 7.5% of the employee's gross wages as defined in Section 3121(a) and 3121(v) of the Internal Revenue Code up to the maximum annual amount established by the Federal Government for Social Security contributions. The combined contribution shall not exceed the annual 457(b) limit prescribed by the Secretary of the Treasury or 100% of the employee's annual compensation; whichever is less.
3. 100% of contributions shall be placed in a fixed asset account maintained by the County's current Investment Provider.
4. All rights to deferred compensation shall be governed by the terms and conditions of the Plan.

Beneficiary Designation

Please print. Changes must be initialed by the Account Holder. Total Percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary. Contingent Beneficiary(ies) will only receive payment if all Primary Beneficiaries have predeceased the Account Holder.

Designation	Enter Complete Legal Name and Phone #	Date of Birth (mm/dd/yyyy)	Relationship	Social Security Number	Percentage of Benefit
☐ Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Account Holder Marital Status - Account Holder MUST select one option.

☐	I am unmarried; therefore spousal consent is not required.
☐	I am married and have designated my Spouse as my sole Primary Beneficiary entitled to 100% of my account balance(s); therefore spousal consent is not required
☐	I am married and have designated someone other than my spouse as my Primary Beneficiary to receive the portion of my account balance(s) to which my spouse is entitled, my spouse must consent to my election by completing the Spousal Consent section.
☐	My Spouse cannot be located or I am legally separated or abandoned within the meaning of local law (retain legal supporting documentation in your files); therefore spousal consent is not required.

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Spousal Consent - Spouse must complete if Account Holder does not designate his/her spouse as the sole Primary Beneficiary

I understand that the Plan in which my Spouse participates entitles me to a benefit payment, if any, in the event of my Spouse's death. Without my consent, my Spouse cannot designate another beneficiary. By signing below i consent and understand that I will not receive any benefit payment unless i am a named beneficiary.

Spouse's Name (Print & Sign)	**Date**

I certify the the above named spouse whose signature appears above personally appeared before me this date to waive his/her rights as Primary Beneficiary to any death benefits payable from the named Plan.

Witness Signature	**Date**

Witness Name and Title (Print) - *Witness must be a Notary Public or Plan Sponsor Representative*

Under penalties of perjury I declare that, to the best of my belief, the information on this form is true, correct and complete. I acknowledge i have read the instructions that accompany this form and understand the conditions and requirements that apply to this beneficiary designation.

Employee Name (Print & Sign)	**Date**

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

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