CARVER PUBLIC SCHOOLS

TO: **PART-TIME, SUBSTITUTE & ATHLETIC EMPLOYEES**

FROM: Financial/Payroll Administrative Assistant

RE: **PAYROLL DEDUCTION - FICA (SOCIAL SECURITY)**

A federal law effective July 1, 1991 required employees who are not members of the Plymouth County or Massachusetts Teachers' Retirement System to be subject to social security withholding. The Carver Board of Selectmen voted to accept MA General Laws, Chapter 474 of the Acts of 1991 requiring that all substitute/casual employees of the Town of Carver contribute 7.5% of their gross pay to an alternative plan in place of social security.

This money will be invested with the VOYA Financial (Voya Retirement Insurance and Annuity Company) through section 457 Deferred Compensation Plan. The deduction, plus interest, will be returned to you upon retirement, separation of service from the Town of Carver (unless you choose to leave it in your account), or in the event of an "unforeseeable emergency". **This is NOT a voluntary plan, it is MANDATORY.**

If you are presently covered elsewhere by Plymouth County Retirement, MA Teachers' Retirement, or receiving retirement benefits from these programs, please return forms with appropriate documentation.

If you have any questions concerning this process, call Casey Kruja in the Business Office/Payroll Department at 508-866-6170.

Questions regarding the VOYA Plan and the investment of your money should be directed to Jen George, VOYA Agent, at 508-580-8714.

Enrollment Form

For Part-Time Employees In 457 Public Employer Deferred Compensation Plans

Voya Retirement Insurance and Annuity Company
P.O. Box 990063
Hartford, CT 06199-0063

Fax Number: 1-800-643-8143

In this form, Voya Retirement Insurance and Annuity Company may also be referred to as the Company. Eligibility to receive Employer Contributions is determined by the Employer. Completion of this Enrollment Form does not establish your eligibility to receive Employer Contributions.

Information About You

Please print.

Changes to the Social Security No. or Date of Birth must be initialed by the Participant.

Employer Name	Billing Group No.
TOWN OF CARVER -- CARVER PUBLIC SCHOOLS	

Participant Name (*First, Middle Initial, Last*)	Social Security No.

Participant Resident Address *(No. & Street)*	PO Box

City/Town	State	Zip Code

Date of Birth	Home Telephone No.	Work Telephone No.
	( )	( )

Anti-Fraud Statement

We are required by the insurance regulations of your state to provide you with the following information: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Mandatory Salary Reduction

I acknowledge that I have received the Fixed Annuity Disclosure Booklet and understand that all contributions will be deposited into the Voya Fixed Account [002].

Signature

This Agreement is made between the Participant and the Employer. I understand that the information indicated above will remain in effect until later changed or revoked by me. I also understand that I am required to contribute a mandatory amount (as defined by my Employers Plan) into the Voya Fixed Account until my status as a Part Time employee is otherwise changed as permitted by the plan.

Participant's Signature	Date *(mm/dd/yyyy)*

Beneficiary Designation Form

Part-Time Employee – Section 457

Deferred Compensation Program

Participant Information

Participant Name (Last, First, MI	Social Security No.	Date of Birth (mm/dd/yyy)	Sex (M/F)
Street Address	City	State	Zip
Work Department (Location)	Work Phone	Cell Phone	Home Phone

Primary Beneficiary Information

Beneficiary Name (Complete legal name required)	Beneficiary Social Security No.		Primary Beneficiary Percentage
Beneficiary Street Address	City	State	Zip
Beneficiary Date of Birth (mm/dd/yyy)			Relationship

Contingent Beneficiary Information

Contingent Beneficiary Name (Complete legal name required)	Contingent Beneficiary Social Security No.		Contingent Beneficiary Percentage
Contingent Beneficiary Street Address	City	State	Zip
Contingent Beneficiary Date of Birth (mm/dd/yyy)			Relationship

Contingent Beneficiary Name (Complete legal name required)	Contingent Beneficiary Social Security No.		Contingent Beneficiary Percentage
Contingent Beneficiary Street Address	City	State	Zip
Contingent Beneficiary Date of Birth (mm/dd/yyy)			Relationship

Contingent Beneficiary Name (Complete legal name required)	Contingent Beneficiary Social Security No.		Contingent Beneficiary Percentage
Contingent Beneficiary Street Address	City	State	Zip
Contingent Beneficiary Date of Birth (mm/dd/yyy)			Relationship

I have read and acknowledge the above provisions and those contained on attachments to this Agreement. I understand that my election above will remain effective until later changed or revoked.

_______________________ _______________________ _______________

Participants Signature *Printed Name* *Date*