San Joaquin County Health Benefits Enrollment Form 2021 – 2022

Employees in Units: C (Middle Management Non-Cafeteria), D (Confidential Non-Cafeteria), E (Professional), F (Para-Professional & Technical), G (Office & Office Technical), H (Safety, Investigative & Custodial), I (Trades, Labor, and Institutional), M (Registered Nurses), N (Correctional Officers), P (American Physicians and Dentists), Q (Peace Officers Misc.), R (Supervisors), S (Unrepresented Physicians), T (Attorneys), U (Probation Officers), and X (Unassigned CRNAs Only)

Reason for Enrollment Form: ☐ Open Enrollment ☐ New Hire ☐ Qualifying Life Event: _____ (Describe)

For HR staff use only
Effective Date: _____

For any questions or to submit this form, contact Human Resources Employee Benefits Office at (209) 468-9987
Email: employeebenefits@sjgov.org. Fax: (209) 468-9734. Mailing address: 44 North San Joaquin Street Suite 330, Stockton, CA 95202

Employee Personal Information			
First Name, Middle Initial, Last Name:		Employee ID#:	
Street Address:	City:	State:	Zip Code:
Date of Birth:	Social Security Number:		
Best Contact Phone Number: ☐Mobile ☐Home			☐Male ☐Female
Email Address:			

Medical Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Medical Plan Options	Coverage Level	Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
☐Select Exclusive Plan ☐Select Plan ☐Premier Plan ☐Sutter Health Plus HMO ☐Kaiser Permanente HMO ☐Sutter Health Plus – High Deductible Health Plan (HDHP) ☐Kaiser Permanente – High Deductible Health Plan (HDHP) ☐Opt-Out of Medical	☐Employee Only ☐Employee + One ☐Employee + Family	Select Exclusive	$132.94	$265.87	$372.22
		Select Plan	$132.94	$265.87	$372.22
		Premier Plan	$188.75	$377.49	$528.47
		Sutter Health Plus	$75.40	$150.81	$213.42
		Kaiser HMO Plan	$76.10	$152.19	$215.35
		Sutter Health Plus HDHP	$56.65	$113.31	$160.33
		Kaiser HDHP	$58.70	$117.40	$166.13

-Employee's Primary Care Physician (PCP) code for Sutter Health Plus (required):
(Dependent PCP codes need to be listed on back)
-Go to www.sutterhealthplus.org/provider-search to find a PCP or one will be auto-assigned to you)

Dental Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Dental Plan Options	Coverage Level	Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
☐Delta Dental (Standard) ☐Delta Dental (Core) ☐Delta Dental (Buy Up) ☐United Healthcare (UHC) Dental ☐Opt-Out of Dental	☐Employee Only ☐Employee + One ☐Employee + Family	Delta Dental (Standard)	$0.00	$18.42	$44.07
		Delta Dental (Core)	$0.00	$17.88	$42.76
		Delta Dental (Buy Up)	$1.04	$20.45	$47.48
		UHC Dental	$0.00	$9.52	$17.92

Your dental office for UHC Dental (required):

Vision Plan Option

Vision Plan	Coverage Level	Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
☐VSP (Standard) ☐VSP (Buy Up) ☐Opt-Out of Vision	☐Employee Only ☐Employee + One ☐Employee + Family	VSP (Standard)	$0.00	$2.61	$6.72
		VSP (Buy Up)	$2.01	$6.61	$13.90

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Only for High Deductible Health Plans: Health Savings Account (Optional)

The County will contribute $700 annually (divided by 26 pay periods) towards an employee's Health Savings Account (HSA) who elects a High Deductible Health Plan (HDHP) at the employee only coverage level. The County will contribute $1,400 annually (divided by 26 pay periods) towards an employee's HSA who elects a HDHP at the employee + one or employee + family coverage level. Employees have the option to contribute the difference between the annual maximum and what the County is contributing on a pre-tax basis. This plan is similar to the Flexible Spending Account as you are able to pay for qualifying health expenses. For more information on this plan, call (833) 232-4673 or email voyasupport@voya.benstrat.com

Enter the annual election for the plan you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the calendar year you are electing coverage for.

Indicate the election change by checking the appropriate box below.

☐ Cancel Future Contributions to the HSA	
☐ Begin Contributions (First HSA Contribution this year)	$ _____ Optional Annual Employee Contributions to the HSA
☐ Change Contributions	$ _____ Optional Annual Employee Contributions to the HSA

The IRS has established annual limits that can be contributed to a Health Savings Account in 2021, which are $3,600 for single coverage and $7,200 for 2-Party or Family coverage (including the County's Contribution of $700 for employee only or $1,400 for employee + one/employee + family).

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." **IRS guidelines define an HSA Eligible individual as a person who:**

- **is covered under a HSA-qualified high deductible health plan (HDHP), and**
- **has "no other health coverage" (except what is permitted by the IRS), and**
- **is not enrolled in Medicare, and**
- **cannot be claimed as a dependent on someone else's tax return.**

By law, you are not eligible for HSA contributions if you:

- are enrolled in Medicare* (Part A, Part B, Medicare Advantage Plans, Part D, and Medigap/Medicare Supplemental Insurance),
- are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- can be claimed as a dependent on someone else's tax return,
- are covered by a non-HDHP such as Medicaid, TRICARE or TRICARE for Life, or
- are enrolled in a general purpose Health Care Flexible Spending Account or Healthcare Reimbursement Account (or covered by a spouse's FSA or HRA).

*With respect to being enrolled in Medicare, if you are enrolling in Medicare after attaining age 65, **HSA contributions generally should be discontinued at least six (6) months prior to filing for Medicare benefits**, because Medicare enrollment (called Medicare entitlement) can occur retroactively if you apply after you attain age 65. In such case, if you do not stop HSA contributions in a timely fashion, i.e., the six (6) months (or the months between turning age 65 and the date of application, if shorter) before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have made an excess contribution and incur a tax penalty.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are not required to prorate your contributions to your health savings account and can make the full year's contribution to your HSA account. However, if you base an entire tax year's contribution on your status on December 1 (and you were not HSA eligible for that entire year) and you cease to be an eligible individual before the end of the following year, any funding of the HSA over the prorated amount for the months of actual eligibility in the prior year is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

A few states including California may not conform their state tax laws with federal tax laws and contributions to the HSA may be taxed under these state laws. It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA.**

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I understand that in order for the County of San Joaquin to contribute to a health savings account (HSA) on my behalf, I must meet all of the following conditions for HSA eligibility:

- **I am covered under the County's Kaiser or Sutter Health Plus HSA-Qualified High Deductible Health Plan (HDHP), and**
- **I have "no other health coverage" (except what is permitted by the IRS), and**
- **I am not entitled to Medicare, and**
- **I cannot be claimed as a dependent on someone else's tax return.**

By signing below, I certify that all of the above statements are true. I agree to promptly notify the County of San Joaquin Human Resources Employee Benefits Office in writing if I cease to meet these conditions. I understand that the County will make contributions to my HSA only on the basis of my certifications, and that HSA contributions are subject to certain limits under federal tax law. **I further acknowledge that employee contributions are taken out of my pay check on a pre-tax basis, and that a monthly administrative fee (currently $1.15 per month) will be deducted from my HSA account. Additional fees also apply if I utilize VOYA's optional investment account options within my HSA account.**

Signature:_____ Date_____

Section 125 – Flexible Spending Accounts

If you have elected to enroll in either of the High Deductible Health Plan options, you are ineligible to enroll in the Medical Flexible Spending Account. You may elect the Health Savings Account in lieu of the Medical Flexible Spending Account listed above.

Enter the annual election for the plans you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the fiscal year you are electing coverage for. (The months with 3 paychecks, only 2 paychecks have deductions.) ***New Hires can enroll, but on a prorated amount.**

Plan Options

Medical Spending Account
(Elect up to $2,750* for 2021 – 2022 annually) $_____ annually

Dependent Day Care Account
(Elect up to $5,000 for 2021 – 2022 annually) $_____ annually

☐ I acknowledge that I have received a copy of the **Rules of Participation** and understand and agree to the terms and conditions of participation in the Flexible Spending Account(s), including those of the Flexible Spending Account Card.

Eligible Dependent Coverage

Check the box for the health services you wish to enroll your eligible dependents. You, as the employee, must be enrolled in the plan if you want your dependent(s) enrolled. If your dependents are enrolled, the plan selection(s) must be the same as the employee.

Required Documentation:
Social Security Number for all, Marriage Certificate (spouse), Birth Certificate (child),Certificate of Partnership (registered domestic partner), court paperwork (adopted child/legal guardianship)

Dependent(s) Name (spouse and/or children)	Relation-ship	Date of Birth	Social Security Number (required)	Medical	Dental	Vision	Primary Care Physician (PCP)

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Other Medical Coverage:

Is your spouse or any of your eligible dependents covered by another group medical plan, including San Joaquin County coverage, MediCal, or Medicare?

☐Yes. Name and Address of Other Medical Coverage_____

☐No. I certify that my spouse and/or dependents are not covered by any other medical coverage.

Kaiser Foundation Health Plan Arbitration Agreement

Please read and sign if you are electing the Kaiser plan (required).

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not be lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

Employee Signature **Date**

Sutter Health Plus Plan Arbitration Agreement

Please read and sign if you are electing the Sutter Health Plus plan (required).

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration

Sutter Health Plus (SHP) handles/resolves member disputes through grievance, appeal and independent medical review processes. In the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes. As a condition of your membership in SHP, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and SHP, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *EOC*.

Employee Signature **Date**

Qualifying Life Events

If you obtain a new dependent (through marriage, birth, adoption, registered domestic partnership, legal guardianship) or if you or your dependents lose medical, dental, and/or vision coverage, you must request enrollment in the County's plans within 60 days of the date of the event. If you do not request enrollment within 60 days, you or your dependent must wait until the next County Open Enrollment period before you can enroll and/or make changes. It is also the employee's responsibility to delete a spouse or dependent from coverage within 60 days of an event that makes the dependent ineligible for benefits (such as divorce or over-age child).

By signing below, I acknowledge that deductions are taken out of my pay check on a pre-tax basis. I must provide all dependent verification documentation within 60 days from my date of hire or qualifying life event. Rates are negotiated through my bargaining unit and approved by the Board of Supervisors. All dependents enrolled must be eligible. I understand that falsification of information by me will allow my employer to recover payments made, cancel my coverage, refuse payment of claims, and may include discipline.

Signature: _____ **Date:** _____

GROUP TERM LIFE INSURANCE
BI-WEEKLY RATES FOR ADDITIONAL INSURANCE

The County provides Group Term Life Insurance for all employees who are eligible for County benefits. Eligible employees may purchase additional insurance in $25,000 increments from the County's current insurance carrier, ReliaStar. Payroll deductions for additional life insurance are deducted bi-weekly.

All members may purchase up to $200,000.

COVERAGE	BI-WEEK RATE	COVERAGE	BI-WEEK RATE	COVERAGE	BI-WEEK RATE	COVERAGE	BI-WEEK RATE
$25,000	$3.20	$50,000	$6.39	$75,000	$9.59	$100,000	$12.78
$125,000 *	$15.98	$150,000 *	$19.17	$175,000 *	$22.37	$200,000 *	$25.56

Evidence of Insurability Required for Amounts over $100,000 and any amount after 31 days from date of hire.

Andre Hamil
We help our MHN members get the support they need.

Your Employee Assistance Program

How can we help?

Life can be complicated. With MHN, getting help is easy.

Your EAP is here to help with life's many challenges. MHN provides the following services, paid for by your employer.

Problem-solving support

Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about your use of alcohol or drugs.

When you call, you can make an appointment that works for you:

- **Face-to-face sessions** – Meet with a provider from our network (for example, a counselor, marriage and family therapist, or psychologist) in his or her office. We can provide a referral when you call us. You can also search for a provider on our member website.
- **Phone or web-video consultations** – Easily accessed support provided by a network provider or MHN consultant.

Remember that EAP services are not medical care or mental health treatment of any kind. If, in the course of a consultation, clinical problems are suspected, including drug or alcohol problems, we will offer a referral to appropriate medical or mental health services.

Work and life services

Our experts can help you balance your work with your life![1] Call us for:

- **Childcare and eldercare assistance** – We'll find out what kind of help you need caring for children or elders in your life. Then we'll give you names and numbers of providers in your area with confirmed openings.
- **Financial services** – Talk to an advisor over the phone about:
  - Budgeting
  - Credit and financial questions (investment advice, loans and bill payments not included)
  - Retirement planning

- **Legal services** – Talk to a lawyer over the phone or face to face about:
  - Civil, consumer and criminal law
  - Personal and family law, including adoption, divorce and custody issues

(continued)

[1]Please contact us for details, including limitations and exclusions.

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  - Financial or tax matters. (Business matters are excluded. Also excluded are any disputes or actions between members and their employer, business partners, MHN, Health Net, or their affiliates.)
  - Real estate
  - Estate planning

- **Identity theft recovery services** – Speak with a certified consumer credit counselor who can learn more about your situation and help you create a plan. If there is a potential of ID theft, we'll connect you to an identity recovery specialist.

- **Daily living services** – Need help with errands? Planning an event or a vacation? We'll track down businesses and consultants for you. (MHN does not cover the cost nor guarantee delivery of vendors' services.)

Our member website can help with:

- Childcare and eldercare directories.
- Tips, tools and calculators to help you with finances, legal issues and retirement planning.

Health and wellness resources

Take charge of your well-being! MHN can help. Just register on our member website to:

- Assess your health and get tips for living better.
- Track progress toward your wellness goals.
- Take advantage of interactive e-learning programs.
- Find articles and videos about health topics.

Call your EAP number to learn more about our wellness coaching services – personalized support to help you set and reach your wellness goals.

This is just a summary. For details about services and eligibility, please contact MHN or your employer, or check your plan documents (such as an *Evidence of Coverage* booklet or *Summary Plan Description*).

Your privacy

EAP services are confidential. Your privacy is important to us, and it is protected by state and federal laws.

Need help?

Call toll-free, 24 hours a day, seven days a week: 1-800-242-6220
TTY users call 711.
Or visit us at: members.mhn.com
and register with the company code: sanjoaquin

You are entitled to up to 5 face-to-face sessions or telephonic or web-video consultations for problem-solving support per incident, per plan period.
Separate limits apply for work-life consultations.

We speak your language!

When you call MHN, free interpretation services are available in over 170 languages. We also contract with a vendor who can physically attend appointments with you, at no cost, if you need help communicating with doctors or other providers.

¡Hablamos su mismo idioma!

Cuando llame a MHN, podrá usar nuestros servicios de interpretación gratuitos en más de 170 idiomas. Además, contamos con proveedores contratados que pueden asistir en persona a las citas con usted, sin cargo alguno, en caso de que necesite ayuda para comunicarse con los médicos u otros proveedores.

我們說您的語言!
您致電 MHN 時，我們可提供 170 多種語言的免費傳譯服務。我們還聘用了翻譯人員，如果您需要翻譯人員幫助您與醫生或其他醫療服務提供者進行交流，該翻譯人員可以與您一道參加約診，該服務爲免費提供。

Security when you travel

Voya Travel Assistance

We live in a highly connected world where frequent domestic and international travel is the norm. Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependents will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world. Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Available services

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services: Pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Pre-trip information

These valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including:

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information

Emergency personal services

In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including:

- Urgent message relay
- Interpretation/ translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

If you need emergency or pre-trip services...

...use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program.

You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described.

Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.

Voya Travel Assistance

Contact Voya Travel Assistance 24 hours a day, 365 days a year for: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Group name: CSAC-EIA / Group number: 316407
In the US, toll-free: 800.859.2821
Worldwide, collect: 202.296.8355
Email: ops@europassistance-usa.com
Online portal:
https://eservices.europassistance-usa.com/sites/Voya
Group ID: N1VOY
Activation code: 140623

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

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Emergency transportation services*

Should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance- designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf. Additional transportation services include:

- Visit of family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

* The services listed above are subject to a maximum total payment of $150,000.

Medical assistance services include:

- Medical referrals for local physicians and dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant)

How it works

At any time before or during a trip, you may contact Voya Travel Assistance for assistance services. It is recommended that you keep a copy of this summary with your travel documents. Use the wallet card to have convenient access to the numbers that you need.

Exclusions and limitations

A. Voya Travel Assistance shall not provide services enumerated above if the service is sought as a result of your or your dependent's:

Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power;

- Travel against the advice of a physician;
- Travel for the purpose of obtaining medical treatment;
- Travel in any country in which the U.S. State Department issued travel restrictions;
- Commission of or attempt to commit an unlawful act;
- Being under the influence of drugs or intoxicants unless prescribed by a physician;
- Pregnancy and childbirth (except for complications of pregnancy);
- Mental or emotional disorders, unless hospitalized;
- Participation as a professional in athletics;
- Services provided for which no charge is normally made;
- Travel within 100 miles of your permanent residence, unless in a foreign country.

B. The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, Voya Travel Assistance may not be able to respond in the usual manner.

It is your responsibility to inquire whether a country is "open" for assistance prior to your departure and during your stay. Voya Travel Assistance also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit Voya Travel Assistance to fully provide services.

C. If you request a transport related to a condition that has not been deemed medically necessary by a physician designated by Voya Travel Assistance in consultation with a local attending physician or to any condition excluded hereunder, and the Employer or Plan Sponsor agrees to be financially responsible for all expenses related to that transport, Voya Travel Assistance will arrange but not pay for such transport to a medical facility or to your residence and will make such arrangements using the same degree of care and completeness as if Voya Travel Assistance was providing service under this agreement. A waiver of liability will be required prior to arranging these transportation services.

D. Voya Travel Assistance shall not be responsible for any claim, damage, loss, cost, liability or expense which arises in whole or in part as a result of Voya Travel Assistance's inability to reach the Employer's or Plan Sponsor's authorized Contact person for any reason beyond Voya Travel Assistance's control, or as a result of the failure and/or refusal of the Employer or Plan Sponsor to authorize services proposed by Voya Travel Assistance.

Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

204331-02012019

PLAN | INVEST | PROTECT

VOYA® FINANCIAL

Peace of mind
when it's needed the most

Funeral Planning Services

Available to employees who are covered for group life insurance through their employer. Funeral planning and concierge services are provided by Everest Funeral Package, LLC.

Everest is pleased to provide a value-added service that empowers individuals who are dealing with funeral related issues.

While you can't predict life's outcome,
you can prepare for it.

EVEREST
FUNERAL CONCIERGE

Who is Everest?

Everest, the first nationwide funeral planning and concierge service, is an independent consumer advocate who works on your behalf. Everest's sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues and then put those wishes into action.

You're never locked into a decision because Everest's funeral advisory services can be used at any funeral home across North America.

Everest is an impartial consumer advocate, not a funeral home. Everest does not sell funeral goods or services, nor does Everest receive any commissions from funeral homes or other service providers in the funeral industry. With Everest, you are removed from a sales-focused environment, allowing you and your family to make well-informed and confident decisions during a stressful time.

Everest offers both pre-planning and at-need services at or near the time of need. Everest's online planning tools help you prepare for the future. At-need services include price negotiation assistance and communicating the family's wishes to the funeral home. Everest Advisors are available by phone 24/7 and can determine eligibility for the expedited life insurance claim process.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

VOYA® FINANCIAL

Everest's services include

Who is eligible?

Everest can be used to plan a funeral for an employee; a spouse or domestic partner; or an employee's dependents up to age 26.*

Pre-planning Services

24/7 advisor assistance

- To discuss funeral planning issues

PriceFinder℠ research reports

- The only nationwide database of funeral home prices
- Detailed, local funeral home price comparisons

Online planning tools

Include

- Personal profile
- "10 key decisions" planner
- "My Wishes" planning guide
- Reference guide

Information stored and maintained in a secure data warehouse

At-need Services

At-need family support

- Family assistance and plan implementation
- Communicate the personal funeral plan to the funeral home, removing the family from a sales-focused environment
- Provide 24-hour assistance throughout the funeral process
- Expedited life insurance claim process. Eligible beneficiaries may have access to a portion of the life insurance funds in as little as two business days following receipt of the claim form.**

Negotiation assistance

- Gather pricing information and present it to the family in an easy-to-read format
- Negotiate funeral service pricing with local funeral homes
- Help the family compare prices of caskets and other products

* Spouse or domestic partner coverage varies depending on the terms of your employer's group life insurance policy.

**Availability may vary by state.

Getting started

Group name: CSAC-EIA
Group number: 316407

Create an online profile and use Everest's planning tools visit **everestfuneral.com/voya**

- Enter your email address and your employer's name
- Create a password and complete your online profile
- Access "Planning Tools"

If you do not have access to a computer, Everest advisors are available 24/7 by calling **1-800-913-8318**.

EVEREST FUNERAL CONCIERGE

Contact your employer for more information.

Funeral Planning and Concierge Services are provided byEverest Funeral Package, LLC, Houston, TX.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies
Products and services may not be available in all states.

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MassMutual

County of San Joaquin Enrollment/Participation Agreement

Return this form to the Auditor-Controller's Payroll,
44 N. San Joaquin Street, Ste 550, Stockton CA 95202

Fax Number: 209-468-0408

Section A - Plan and Participant Information

Account No **62116-1-1**	Social Security Number	Employer **County of San Joaquin 457b**	Employee ID:
Participant Name (Last, First, M.I.)		Daytime Phone Number	
Mailing Address	City	State	Zip Code
E-mail	Gender: ☐ Male ☐ Female / Marital Status: ☐ Single ☐ Married	Hire Date	Date of Birth

Section B - Contributions

Elective Deferral Per Pay Period *($10.00 Minimum)*

1. ☐ **BEFORE TAX:** I elect to contribute $ _____ or _____ % of my compensation each payroll period on a before-tax basis.
2. ☐ **AFTER TAX:** I elect to contribute $ _____ or _____ % of my compensation each payroll period on an after-tax basis.
3. ☐ I do not elect to contribute a portion of my salary at this time.

Section C - Investment Elections

Future contributions will be invested in an age-based target investment option. You may select an investment option from the investments made available to your plan. To make any investment elections or changes please visit **www.retiresmart.com or call 1-800-743-5274**.

The employee acknowledges that he or she has had an opportunity to review the important plan disclosures included in the plan welcome/enrollment package previously delivered to the employee, and that important plan disclosure information can also be obtained by contacting MassMutual at 1-800-743-5274 or linking to Account Access from www.retiresmart.com.

Section D - Beneficiary Designation

I designate the following beneficiary(ies) in accordance with the 457(b) Deferred Compensation Plan

Primary Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
			PRIMARY TOTAL:	100%

Contingent Beneficiary (optional): If no Primary Beneficiary listed above is alive upon my death, I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100 %.)

Contingent Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
			CONTINGENT TOTAL:	100%

NOTE: If you are married and designate your spouse for less than 100% of your death benefit, you must complete a full Beneficiary Designation/Spousal Consent form. You can obtain this via your payroll department.

NOTE: MassMutual will not display Contingent Beneficiary information on our participant website at www.retiresmart.com. An electronic copy of this form is kept on record.

Section E - Employee Agreement and Signature

If elected above, I authorize that any Before-Tax or After-Tax Contributions indicated above be made by reducing the Employee's net pay. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 457(b) contributions to ensure the Plan satisfies the requirements of Section 457(b). The execution and the delivery of this form to the offices of MassMutual revokes all prior beneficiary designations that I have made. I understand that this beneficiary designation will not take effect until it has been received in good order by MassMutual.

Participant Signature _____ Date _____

Section F - Important Information

BENEFICIARY INFORMATION

Please complete the Beneficiary Designation including name, address, phone number, Social Security Number, date of birth, relationship and percentage of death benefit. The percent of benefit must total 100% for all primary beneficiaries named. If naming contingent beneficiary(ies) the total percentage for this designation must equal 100%. Married residents of community property states may want to seek legal advice if naming a non-spouse Primary Beneficiary.

Type of Beneficiary:		Examples of Designations:
One Beneficiary		Jane Doe, wife, 100%
Two or more Primary Beneficiaries, equally among the survivors		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivors
Two or more Primary Beneficiaries, with their share to their children		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% per stirpes
Primary and Contingent Beneficiaries	either or	Primary: Jane Doe, wife, 100% if living; Contingent: John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% equally among the survivors per stirpes
Participant's Estate		Participant's Estate
Trustee		Jane Doe, trustee under trust agreement* dated...

* Date of the execution of the trust agreement or a copy of the trust agreement must be provided.

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 • Stockton, CA 95202 • (209) 468-2163 • contactus@sjcera.org • www.sjcera.org

BENEFICIARY DESIGNATION

Please type or print in ink. Please refer to the instructions for this form if you have any questions or contact our office.

MEMBER

First Name	Middle Name	Last Name	
Mailing Address			CAPS (Employee) ID Number
City	State	Zip Code	Date of Birth
Home Telephone Number	Work Telephone Number		Social Security Number
E-Mail Address			○ Male ○ Female ○ Single ○ Married

PRIMARY BENEFICIARIES

I hereby designate the following person(s) who survive me as beneficiaries for death benefits under the County Employees' Retirement Law of 1937 in the event of my death. I understand that if I die after becoming eligible for service retirement, this beneficiary designation may be superceded in certain cases and benefits paid according to law to my eligible surviving spouse or minor children; or, if my death is determined to be service connected, special death benefits will be paid in the manner prescribed by law. If no percentage (%) share is designated, benefits will be paid share and share alike.

1	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %
2	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %
3	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %

If you wish to designate additional primary beneficiaries, please list their name(s), address(es), SSN(s) and relationship(s) to you and share(s) on a separate piece of paper and attach it to this form. ☐ Additional beneficiaries listed on attached.

SIGNATURE

By this beneficiary designation, I hereby revoke any previous designation I have filed. I understand that my marriage, initiation of dissolution or annulment of my marriage, or the birth or adoption of a child subsequent to the date I execute this form may void this designation.

Member Signature	Date	Witness Signature (cannot be a beneficiary)	Date
By signing the beneficiary designation form, I acknowledge the information entered by my spouse. Spouse Signature:	Date	Print Witness Name	

☐ I certify under penalty of perjury that I am not currently legally married (e.g., divorced, widowed, or never married)

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 • Stockton, CA 95202 • (209) 468-2163 • (209) 468-0480 Fax • www.sjcera.org

DESIGNATION OF BENEFICIARY

The Basic Death Benefit payable by the SJCERA upon the death of a member prior to retirement consists of the member's accumulated contributions and interest, plus up to six months of the member's final average monthly salary, depending on the years of retirement service credit. This benefit is also referred to as the "lump sum death benefit." The member's surviving spouse or minor children may be eligible for other benefits in lieu of the Basic Death Benefit. These other benefits are also referred to as "survivor continuance." Please refer to the SJCERA Retirement Plan Information booklet for further details concerning pre-retirement death benefits.

Please complete the Beneficiary Designation (Form 110) to designate a beneficiary or beneficiaries to receive the lump sum death benefit payable from the SJCERA in the event of your death prior to retirement.

- You may designate any person(s) or your estate as beneficiaries.
- You may designate a minor child as your beneficiary. **Do not** name a guardian of the minor child in addition to, or instead of, the minor child. If benefits are payable to a minor child, the court-appointed guardian will be responsible for any benefits paid to the child. (Note: A parent who has custody of a minor child is not required to be appointed by the court as a guardian in order to claim a benefit on behalf of that child.)
- You may designate a trust as your beneficiary. However, if you wish to designate a trust, the following information should be provided: The name of the trust, date of trust and name/address of the person with whom the trust is on file.

Also, unless you specify otherwise, the beneficiary you designate on Form 110 will also be the beneficary for any group life insurance benefits provided by your employer (San Joaquin County) for which you may be eligible.

INSTRUCTIONS FOR COMPLETING FORM 110

1. MEMBER INFORMATION

a. Enter your full legal name (no middle initials), social security number, date of birth, current mailing address, and home and work telephone numbers.

b. Enter your e-mail address if you have one. This is voluntary and your e-mail address will remain confidential with the SJCERA.

c. Fill-in the appropriate bubble to specify your gender and current marital status.

2. PRIMARY BENEFICIARIES

Use this section of the form to designate the beneficiary or beneficiaries who are to receive the lump sum death benefit benefit payable from the SCJERA in the event of your death prior to retirement. **If you are legally married and designate someone other than your spouse as your beneficiary, your spouse may still be entitled to his/her community property interest in the lump sum and/or survivor continuance death benefits.**

For each primary beneficiary, you must designate:

a. Full first, middle and last name, Social Security number, complete mailing address, birthdate, and relationship to you.

b. If you designate more than one beneficiary, designate the percentage share to be distributed to each beneficiary. The total of all shares listed must equal 100%.

Example A: If you have two beneficiaries listed and you would like each of them to receieve half of your lump sum death benefit, enter "50" for each beneficiary in the "Percentage Share" box.

Example: B: If you designate only one primary beneficiary, enter "100" in the "Percentage Share" box.

(CONTINUED NEXT PAGE)

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INSTRUCTIONS FOR COMPLETING FORM 110 - CONTINUED

c. If you want to designate more than three primary beneficiaries, please **ATTACH a separate piece of paper** listing your additional beneficiaries and include all of the same information required. Please write your name and Social Security number at the top of any attached page(s). Fill in the bubble for "Additional beneficiaries listed on attached".

NOTE: ALL primary beneficiaries will be concurrent, rather than successive or contingent, payees.

3. SIGNATURE

a. You must sign and date the form in the presence of a witness (other than a named beneficiary) using your full first, middle, and last name. (Example: John Edward Smith.) An unsigned form is not valid and will be returned to you.

b. If you are married, your spouse must sign and date the form, in the presence of a witness, to acknowledge the names of the beneficiaries you are designating.

c. Have the witness clearly sign and date the form.

NOTE: IF YOU ARE UNABLE TO OBTAIN YOUR SPOUSE'S SIGNATURE, YOU MUST COMPLETE AND RETURN THE JUSTIFICATION FOR NON SIGNATURE OF SPOUSE (FORM 112).

4. SUBMIT FORM

Submit the completed, signed, and witnessed Beneficiary Designation form to the SJCERA via U.S. mail, inter-office mail, or in person to the address shown at the top of the Beneficiary Designation Form. If required, also submit completed Justification for Non Signature of Spouse (Form 112).

IMPORTANT NOTICE

Your Beneficiary Designation may be revoked automatically if any of the following events occur subsequent to the date you execute and submit this Beneficiary Designation form:

a. Marriage; or
b. Dissolution or annulment of marriage **if effected after** the Beneficiary Designation form was submitted; or
c. Birth or adoption of a child; or
d. Termination of employment and withdrawal of your contributions from the SJCERA.

If your beneficiary designation is revoked by one of the above events, benefits will be paid to your statutory beneficiaries (pursuant to the California Probate Code), unless you submit a new Beneficiary Designation to SJCERA. You may request a blank form from SJCERA or download it from our web site at www.sjcera.org.

IF YOU HAVE ANY QUESTIONS ABOUT COMPLETING AND SUBMITTING THIS FORM, PLEASE CONTACT THE SJCERA AT 209-468-2163.

San Joaquin County Employees' Retirement Association
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JUSTIFICATION FOR NON-SIGNATURE OF SPOUSE

If you are legally married and your spouse's signature does not appear on your SJCERA Beneficiary Designation (Form 110), you **MUST** complete and sign this form and submit it with your Beneficiary Designation. Your Beneficiary Designation will not be accepted by the SJCERA without this Justification for Non-Signature of Spouse.

MEMBER

First Name	Middle Name	Last Name	
Mailing Address			Social Security Number
City	State	Zip Code	Date of Birth
Home Telephone Number	Work Telephone Number		○ Male ○ Female
E-Mail Address			

JUSTIFICATION FOR NON SIGNATURE

I am married, but my legal spouse did not sign my SJCERA Beneficiary Designation (Form 110) because either (check **ONLY ONE** of the following):

- ☐ I do not know the whereabouts of my spouse and I have undertaken all reasonable steps necessary to locate my spouse without success; **OR**
- ☐ My spouse has been advised of the application and has refused to sign the written acknowledgement; **OR**
- ☐ My spouse is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**
- ☐ My spouse has no identifiable community property interest in the benefit; **OR**
- ☐ My spouse and I have executed a marriage settlement agreement which makes the community property law inapplicable to the marriage.

SIGNATURE

I certify under penalty of perjury that the foregoing information is true and correct.

Member Signature	Date

San Joaquin County Employees' Retirement Association

6 S. El Dorado Street, Suite 400 Stockton, CA 95202 • (209) 468-2163 • ContactUs@sjcera.org

Membership Certification

Complete and **return this form to your Personnel Office within 3 business days of your start date. Attach a copy of your birth certificate or valid passport**. If you do not have a birth certificate or valid passport, or are unable to obtain one, see the **Age Verification Policy** on www.sjcera.org for other acceptable documents.

1. Member Information

First Name	MI	Last Name	Cell Phone

SSN	Date of Birth	Employee ID Number

2. Previous Employment & Reciprocity

*Previous employment information is needed to determine tier, contribution rate, and eligibility for reciprocity. Reciprocity allows members to move from one eligible government retirement system to another and retain valuable retirement benefits. (**See instructions on back**)*

Most Recent Previous Employer	Retirement System (Refer to list of systems on the back)

Last Date of Employment (under most recent reciprocal retirement system)	First Membership Date (in any previous reciprocal retirement system)

Check applicable statement:	Payroll Use
☐ I have not been an active member of another reciprocal California government retirement system within the last six months. (Active members are generally permanent full-time employees. See list of retirement systems on back.)	Tier 2
☐ I retired from _____ retirement system and subsequently began full-time employment with an SJCERA-participating employer.	Tier 2
☐ I was a member of the _____ retirement system and, within six months, subsequently began full-time employment with a SJCERA-participating employer.	--
☐ My reciprocal system membership began before Jan. 1, 2013 and I left my member contributions on deposit with that retirement system.	Tier 1
☐ My reciprocal system membership began on/after Jan. 1, 2013 or I withdrew (refunded) my member contributions from that retirement system	Tier 2

3. Acknowledgement

I have read this form and its instructions in their entirety. I hereby certify that the foregoing information is true and correct. I understand that incorrect information may require corrections to my SJCERA account including, but not limited to, my membership date, tier and contribution rate. I authorize SJCERA to establish reciprocity if I am eligible and make any necessary corrections to my account including collecting additional contributions if owed.

EMPLOYEE SIGNATURE	DATE

4. Employer Certification *(**See instruction on back**)*

Employing Agency/Department	New Employee's Job Class Title	Employee Hire Date

Employer Designee (signature)	Designee Title	Date

Employee Instructions

Complete and submit this form with a copy of your birth certificate or other proof-of-age documents to your Personnel Office within 3 business days of beginning employment. For more information, visit www.sjcera.org or call 209.468.2163.

Section 2 Instructions: Previous Employment and Reciprocity Information

Your prior public plan benefit information is required to correctly determine your Tier and contribution rate.

Previous Employment with a SJCERA-employer

If you are a Tier 1 member whose contributions remained on deposit with SJCERA when you left SJCERA-covered employment, and you return to a full-time permanent position with the same SJCERA employer within six months, you will retain your previous SJCERA entry age and contribution rate. If you return to the same employer in more than six months, your entry age and contribution rate will be based on your age at reentry into membership. If you return to a different SJCERA-employer after more than six months, you will be placed in Tier 2.

SJCERA Employers		
San Joaquin County	Mountain House Community Svcs. Dist.	SJC Mosquito & Vector Control
Lathrop-Manteca Fire District	SJC Historical Society & Museum	SJC Superior Court
SJC Law Library	Tracy Public Cemetery	Waterloo-Morada Fire District

Previous Employment with another California Government Employer (Reciprocity)

If you were a member of a reciprocal California government retirement system (see list below) within the last six months, reciprocity allows you to link your entry age, service credit and highest average compensation across all your reciprocal systems. Reciprocity may also allow you enter SJCERA as a Tier 1 member, which offers a higher benefit formula.

Reciprocal Retirement Systems				
County Retirement Systems				
Alameda	Kern	Merced	San Diego	Sonoma
Contra Costa	Los Angeles	Orange	San Joaquin	Stanislaus
Fresno	Marin	Sacramento	San Mateo	Tulare
Imperial	Mendocino	San Bernardino	Santa Barbara	Ventura
State Retirement Systems				
CalPERS (California Public Employees Retirement System)	CalSTRS (California State Teachers' Retirement System)	Legislators' Retirement System (LRS)	Judges Retirement System (JRS)	

Tiers

Tier 1 Members: Employees who entered SJCERA membership before January 1, 2013, or who establish incoming reciprocity based on eligible reciprocal system membership before January 1, 2013.

Tier 2 Members: Employees who enter SJCERA membership on or after January 1, 2013; Tier 1 members who terminate and return to a different SJCERA-participating employer after more than six months; SJCERA retirees who return to active membership.

Employer Instructions

1. Collect this *Membership Certification* form from all new or returning full-time benefited employees, verify the date of birth is entered correctly and complete the Employer Certification section.
2. Submit the following completed forms and documents directly to SJCERA within the first week of employment:
   - ☐ Member Certification
     - ☐ Copy of the employee's Birth Certificate, valid U.S. Passport or valid California Real I.D. Card
       See the Age Verification Policy on www.sjcera.org for other acceptable documents.
   - ☐ Beneficiary Designation
   - ☐ Safety Only – Social Security Form SSA-1945 (if applicable)

SJC 401a - Physicians Bargaining Unit

Enrollment Form

County of San Joaquin Money Purchase Plan
County of San Joaquin
62116-2-1

Fax all pages to 209-468-0408

1 Enter your personal information (Please print clearly)

☒ Employee ☐ Surviving Beneficiary (attach notice of death form) ☐ Alternate Payee (attach a QDRO form)

Participant's Name (First, Middle Initial, Last) | Participant's Social Security Number (SSN)

Street Address | Apt. No. | Birthdate: mm - dd - yyyy

City | State: CA | Zip

( ) Daytime Phone | ( ) Evening Phone | E-mail Address

☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single or Legally Separated ☐ Check here to sign up for e-delivery*

Hire Date _____/_____/_____

Payroll Frequency: ☒ Bi-Weekly (26/Yr)

2 Payroll Deduction

Contribution amounts are set as per the Memorandum of Understanding between San Joaquin County and the participant's union.

Enrollment Form

County of San Joaquin Money Purchase Plan
County of San Joaquin
62116-2-1

3 Choose one of the investment strategies from A, B or C below

Your investment strategies are outlined on the following pages. **Choose the one (from A, B or C) that works for you.**

IMPORTANT NOTE: This investment election applies to all future contributions. Investment allocation strategies are a convenient way of allocating your account among certain of the plan's individual investment options. Any investment allocation strategies included in these materials are not intended to be investment advice or recommendations to you and may or may not be appropriate for your circumstances. In applying investment allocation strategies to your individual circumstances, you should consider your other assets, income and investments as well as your risk tolerance. If you direct your contributions or current account balance to an investment allocation strategy, your contributions or account balance will be invested in each of the individual investment alternatives in the percentages indicated for the strategy. The plan may offer other investment options not included in the strategies and the individual investment alternatives included in the strategies may also be available on a stand-alone basis. The Investment Portfolio chart lists asset classes, along with their weightings in the allocation strategy. Additional investment options may exist that are not included in the portfolio. When selecting your investments, choose only **ONE** portfolio from any of the strategies, sign the form and you're done **OR** you can select individual investment options (under Option C) and build your own portfolio. See below for a complete list of options. The investment options available in this plan may change at the direction of the Plan Sponsor. Elections made on this form may be modified to follow the intent of those changes. If you choose investments for only one source group, contributions from other sources will be allocated to those chosen investments.

Until you make your investment selection, your contributions will be invested in the Target Asset Allocation Investment Option listed below which has the target retirement date closest to your 65th birthday. If you are near, at or past your 65th birthday, your contributions will be invested in the target asset allocation investment option that shows no target retirement date. Following your enrollment, you will receive a transaction confirmation that will tell you specifically in which Target Asset Allocation Option your contributions have been invested. Subject to certain restrictions, you may redirect your contributions to any other investment option under the Plan at any time.

A: Age-Based Investment Option (If you make a selection here, do not make a selection under any other option.)

If you select one of these Asset Allocation investment options, based on the date closest to the year you plan to retire, you're almost done! Check the appropriate box and go to Step 4.

- ☐ **T. Rowe Price Retirmnt (2015 Fd)**
- ☐ **T. Rowe Price Retirmnt (2020 Fd)**
- ☐ **T. Rowe Price Retirmnt (2025 Fd)**
- ☐ **T. Rowe Price Retirmnt (2030 Fd)**
- ☐ **T. Rowe Price Retirmnt (2035 Fd)**
- ☐ **T. Rowe Price Retirmnt (2040 Fd)**
- ☐ **T. Rowe Price Retirmnt (2045 Fd)**
- ☐ **T. Rowe Price Retirmnt (2050 Fd)**
- ☐ **T. Rowe Price Retirmnt (2055 Fd)**

Target Asset Allocation Investment Options *are single solutions that offer professional management and monitoring as well as diversification – all in one investment. Each investment option has an automatic process that invests more conservatively as retirement nears and the options are named to coincide with a particular retirement date. Your plan is designed to invest your contributions into one of these options as the default investment based on your date of birth and a projected retirement age of 65. You may always choose new investment options at any time.*

or

B: Custom Portfolio Investment Option (If you make a selection here, do not make a selection under any other option.)

Custom portfolios, based on different risk tolerances, have been arranged using the individual funds available to your plan. **The amounts of each individual fund contained in the different Custom Portfolio options are shown on the right side of the following fund list.** Take the Investor Profile Quiz. Using your investment strategy score and projected retirement date, you may choose one portfolio. If you select one of these Custom Portfolio investment options, you're almost done! Check the appropriate box and go to Step 4.

- ☐ Short Term
- ☐ Conservative
- ☐ Moderate
- ☐ Aggressive
- ☐ Ultra Aggressive

Enrollment Form

County of San Joaquin Money Purchase Plan
County of San Joaquin
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or

C: Individual Fund Option (If you enter selections here, do not make a selection under any other option.)

First, select the individual funds in which you wish to invest. Then, enter the percentage of your contributions to be invested in each of those funds in the space provided. Make sure selections are whole percentages and total 100%. When they add up to 100%, you're almost done! Go to Step 4.

		Breakdowns for Custom Portfolio Options				
Investment Options	All Contributions	Short Term	Conservative	Moderate	Aggressive	Ultra Aggressive
Guaranteed Interest Account	_____%	95%	21%	6%	2%	–
Metropolitan West Tl Rtn Bd Fd	_____%	1%	17%	12%	4%	–
Vanguard Toti Bnd Mrkt Indx d	_____%	2%	16%	11%	5%	–
DFA Infl-Prot Secs Fd	_____%	2%	16%	11%	5%	–
TIAA-CREF High-Yield Fund	_____%	–	–	–	–	–
T. Rowe Price Retirmnt Bal Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2015 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2020 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2025 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2030 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2035 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2040 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2045 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2050 Fd	_____%	–	–	–	–	–
T. Rowe Price Retirmnt 2055 Fd	_____%	–	–	–	–	–
Vanguard Equity-Income Fund	_____%	–	3%	6%	8%	10%
Vanguard Institutional Indx Fd	_____%	–	10%	18%	26%	34%
T. Rowe Price Inst Lg Cp Gr Fd	_____%	–	3%	6%	8%	10%
Wells Fargo Spec Mid Cp Val Fd	_____%	–		1%	2%	1%
Vanguard Mid Cap Index Fund	_____%	–	2%	6%	6%	7%
Vanguard Mid-Cap Growth Fund	_____%	–		1%	2%	1%
DFA US Targeted Value Fund	_____%	–	1%	1%	2%	2%
Vanguard Small Cap Index Fund	_____%	–	3%	6%	7%	9%
Vanguard Sm Cap Grwth Indx Fnd	_____%	–	1%	1%	2%	2%
American Beacon Intl Equity Fd	_____%	–		1%	2%	3%
Hartford International Opp Fd	_____%	–	5%	10%	15%	17%
Invesco Real Estate Fund	_____%	–	2%	3%	4%	4%
Oppenheimer Gold &Spec Min Fd	_____%	–	–	–	–	–
	100%					

Enrollment Form

County of San Joaquin Money Purchase Plan
County of San Joaquin
62116-2-1

4 Sign, date and return your forms

Please provide your signature and mail to: MassMutual Retirement Services, PO Box 219062, Kansas City, MO 64121. After receipt of this form, MassMutual will send you written confirmation once your account has been updated.

I understand I may revoke this election at any time or I may change this election as allowed by the Plan. I understand that the maximum annual limit on contributions is determined under the Plan document and the Internal Revenue Code. Any amounts contributed may be reduced or returned to me as required by these limitations.

X _____ _____

Participant's Signature Date

IMPORTANT NOTE: *IF YOU ENROLL BY MAILING THIS FORM TO MASSMUTUAL, BUT THEN SUBSEQUENTLY CHANGE YOUR ELECTIONS THROUGH THE AUTOMATED PHONE LINE OR THE PARTICIPANT WEBSITE, THE MOST RECENTLY DATED ACTIVITY WILL PREVAIL.*

If you have selected an investment strategy and one or more of the strategy's component investments listed on your enrollment form has been replaced, any contributions that would have been invested in that component investment will be invested according to the investment allocation in effect at the time the strategy is implemented and the new component will be listed on your confirmation form.

Investors should consider an investment's objectives, risks, charges and expenses carefully before investing. For this and other information, see the prospectus available from your plan sponsor, on the participant website at www.retiresmart.com or by contacting our Participant Information Center at 1-800-743-5274 between 8:00 a.m. and 9:00 p.m. ET, Monday through Friday. Read it carefully before investing.

****If you have elected e-delivery in Section 1 above, you are consenting to receive announcements regarding electronically available materials for your retirement plan online. A link to the available materials will be contained within the e-mail announcement. Materials referenced within the e-mail announcement may be viewed electronically, or printed via the internet. Documents will be posted either in HTML or PDF format. By signing up for this service, you are verifying that you possess the ability to view and download HTML and PDF documents. These documents are required under Title I of ERISA and may include, for example, a Summary Plan Description, a Summary of Material Modification, individual benefit statements, investment related information, as well as any notice or communication required under the Internal Revenue code including, but not limited to, loan notes, notices of interest parties, and notices of available distribution options. Enrollment in MassMutual's e-delivery notification program will continue as long as your e-mail account remains active, or until you elect to cancel your enrollment. In the event of an invalid e-mail address, full mailbox, or spam settings, MassMutual will send printed material via mail. The election or cancellation date of the e-mail notification program may result in notifications remaining in their existing delivery method for a short period of time. Adobe Acrobat Reader version 7.0 or higher is required to view retirement statements. Visit www.adobe.com for a free download.***

Don't forget… You may also roll over your eligible distributions from your prior employer's qualified plan.

County of San Joaquin Money Purchase Plan

BENEFICIARY DESIGNATION

Account Number **62116-2-1**

Participant's Name _____ first _____ middle _____ last

Participant's Address _____ street

_____ city _____ state _____ zip

Social Security No. _____ Marital Status: ☐ Married ☐ Single or Legally Separated

IMPORTANT: If no valid beneficiary designation is on file or if designation cannot otherwise be determined, beneficiary will be determined by the plan fiduciary according to plan documents and applicable law.

This designation supersedes any prior designation.

Primary Beneficiary: (Check either box 1 or 2)

1. ☐ **Spouse Primary Beneficiary:** I designate my spouse to receive my entire account balance upon my death.

   Spouse's Name: _____

   Spouse's Social Security No.: _____ Spouse's Date of Birth: _____ mm/dd/yyyy

2. ☐ **Non-Spouse or Multiple Primary Beneficiaries:** I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100%.)

   If applicable, Spouse's Date of Birth: _____ mm/dd/yyyy

Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent

(must total 100%)

If you are married and you have not designated your spouse as primary beneficiary, please have your spouse provide consent below.

SPOUSAL CONSENT: I understand I have a legal right to a death benefit equal to the participant's entire account balance. I consent to waive that legal right in accordance with the beneficiary designation set forth above. I acknowledge that I have a right to limit my consent only to a specific beneficiary and that I voluntarily elect to relinquish such right. I further understand and acknowledge that if I sign this form, no death benefit will be payable to me except as provided above.

_____ Spouse's Signature

_____/_____/_____ Date

The spouse's signature must be witnessed by a Notary Public:

Notary Public:
Notarization of spousal consent can be signed off by a Notary Public. A Notary Seal is not required when participant resides in one of the following states: CT, KY, LA, ME, MI, NJ, NY, RI, VT

Before me, the undersigned notary, personally appeared _____, and proved to me through identification documents allowed by law, which were _____, to be the person who signed the preceding document in my presence and who affirmed to me that they executed the above Consent of Spouse as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal this ____ day of _____, _____

Witnessed: _____ (official signature and seal of notary) State: _____ County: _____

My Commission expires: _____

Contingent Beneficiary (optional): If no Primary Beneficiary listed above is alive upon my death, I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100%.)

NOTE: MassMutual does not retain Contingent Beneficiary information nor will it be displayed on our participant website at www.massmutual.com/retire.

Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent

(must total 100%)

SIGNATURE

I understand that this beneficiary designation supersedes any previous designation.

_____ _____/_____/_____

Participant Date

Fax all pages to 209-468-0408

Sample wording for use in completing this form:

To Designate	*Use This Wording*
1. Your estate	Executors or Administrators of my estate
2. The trustee of the Trust established under your Will	(Name of trustee) as trustee, or the then acting trustee, of the Trust established under (your name) Will dated (date of Will)
3. The trustee of your Revocable or Irrevocable Trust	(Name of trustee) as trustee, or the then acting trustee, of the (name of Trust) established on (date of Trust)

Trust as Beneficiary:

Before designating a trust as the beneficiary of your plan benefit, you should consult an attorney with expertise in trusts and estates law. Some of the factors to consider include:
1. Who is going to be the beneficiary – your spouse, a minor child – and what are their financial needs?
2. Are the protections of a trust desirable?
3. What are the income tax consequences of designating a trust as beneficiary?

The following requirements must be satisfied before your trust beneficiaries will be treated as your retirement plan's designated beneficiary:
1. The trust must be valid under state law.
2. The trust must be irrevocable or must, by its terms, become irrevocable on your death.
3. The trust's beneficiaries must be identifiable from the trust instrument.
4. You must provide trust documentation to the retirement plan provider.
5. All trust beneficiaries must be individuals.

Congratulations San Joaquin County New Hire!

Chimienti & Associates Insurance Services manages the Voluntary Insurance Plans for the County. Please take a moment to review these very important plans that are part of your Employee Benefits Package with San Joaquin County:

Whole Life *with Colonial*

- Permanent Life Insurance with locked in rates Family coverage available. Fully portable.

Term Life *with Colonial*

- Term Life options are available for 10, 20 and 30 year periods.

Cancer Plan *with Colonial*

- Helps with the out-of-pocket expenses that can be incurred if you are diagnosed with cancer. Also includes a Health Screening Benefit. Family coverage available.

Critical Illness Plan *with Colonial*

- Pays a lump sum benefit directly to you in the event of a covered Critical Illness. Also includes a Health Screening Benefit. Family coverage available.

Universal Life *with Transamerica*

- Life insurance with cash build up Locked-In rates. Family coverage available. Fully portable.

Please call Chimienti & Associates at (877) 733-1670 if you would like additional information regarding the above benefits or are interested in enrolling. A benefits counselor will be happy to answer any questions that you may have.

New Career, New Choices

Starting a new job can be overwhelming, and your insurance options can be confusing. What you select may be one of the most important things you do this year.

Get help with your options. Stop by and see an American Fidelity account manager.

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

Critical Illness Insurance

AF™ **Limited Benefit Critical Illness Insurance**

- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Disability Income Insurance

AF™ **Disability Income Insurance**

- can help protect your finances in case of a covered injury or illness
- provides a benefit to help cover costs while you are unable to work
- pays some of your gross monthly earnings

americanfidelity.com/info/disability

Hospital Indemnity Insurance

AF™ **Limited Benefit Hospital Indemnity Insurance**

- helps pay for out-of-pocket costs, like a hospital stay
- when used with a Health Savings Account allows for a tax benefit and potential savings

americanfidelity.com/info/hospital-indemnity

Approximately **every 40 seconds**, an American will suffer a heart attack.

American Heart Association: Heart Disease and Stroke Statistics 2019 At-a-Glance, pg. 2 February 2019.

Plan Year

7/1/2021 - 6/30/2022

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EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR