



# Express Enrollment Form 457 Deferred Compensation Plans

- Carefully complete all sections of this form in blue or black ink.
- Submit the completed form to your employer to enroll in the ICMA-RC 457 Deferred Compensation Plan.

## 1. PERSONAL INFORMATION

Employer Plan Number: **307108**

Employer Plan Name: **City of Oakland**

Social Security Number: (For tax reporting purposes) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Name: \_\_\_\_\_  
Last First MI

Rehired?  Check if yes

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Mobile Phone Number: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Date Employed/Rehired: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

Gender:  M  F Marital Status:  Married  Single Email: \_\_\_\_\_

## 2. INVESTMENT SELECTION

By submitting this form, you understand you have not chosen an investment option. To select an investment option, log into [www.icmarc.org/login](http://www.icmarc.org/login) once your account is established. If you do not select an investment option, your entire account will be invested in the Plan's default investment selection.

## 3. CONTRIBUTION ELECTION

Specify the total percentage or dollar amounts you wish to contribute each pay period. Contributions will begin as soon as administratively possible following the month in which this form is submitted.

Pre-tax contributions of \_\_\_\_\_ % or \$ \_\_\_\_\_ from my pay each pay period.

Roth\* contributions of \_\_\_\_\_ % or \$ \_\_\_\_\_ from my pay each pay period.

\* NOT available in all plans. Please check with your employer to confirm that Roth Contributions are offered in your plan before selecting this option.

## 4. BENEFICIARY DESIGNATIONS

Once your account has been established, log in to your account at [www.icmarc.org/login](http://www.icmarc.org/login) to setup your beneficiary designations.

## 5. SIGNATURES

Sign, date, and submit the completed form to your employer.

\_\_\_\_\_  
Employee Signature

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

\_\_\_\_\_  
Authorized Employer Official's Signature

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

\_\_\_\_\_  
Authorized Employer Official's Name (Please print)

\_\_\_\_\_  
Authorized Employer Official's Title

PLEASE KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS