WV457 RETIREMENT PLUS

STATE OF WEST VIRGINIA DEFERRED COMPENSATION PLAN PARTICIPATION AGREEMENT

Check the appropriate transaction below.

- ☐ Auto Enrollment
- ☐ New Enrollment
- ☐ Decline Automatic Enrollment
- ☐ Agency Transfer
- ☐ Increase/Restart Salary Deferral
- ☐ Decrease Salary Deferral
- ☐ Suspend Salary Deferral
- ☐ Age 50 Catchup
- ☐ Special Catchup
- ☐ Name/Address Change
- ☐ Termination/Retirement

Term Date _____

Last Pay Date _____

PARTICIPANT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ DATE OF BIRTH _____

STREET ADDRESS _____ SOCIAL SECURITY # _____

CITY _____ STATE _____ ZIP _____ DATE OF EMPLOYMENT _____

AGENCY/POLITICAL SUBDIVISION _____

HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

EMAIL ADDRESS _____

Married ☐

Unmarried ☐

DEFERALL ELECTION

Before Tax Contributions: I elect to contribute the following amount per pay period of my compensation as before-tax contributions to the Plan:

☐ $100 ☐ $75 ☐ $50 ☐ $25 Other (write in amount) _____ OR _____ % of salary

Roth Contributions: I elect to contribute the following amount per pay period of my compensation after-tax as a designated Roth contribution to the Plan:

☐ $100 ☐ $75 ☐ $50 ☐ $25 Other (write in amount) _____ OR _____ % of salary

EFFECTIVE DATE _____

EMPLOYEE AGREEMENT TO PARTICIPATE IN 457 DEFERRED COMPENSATION PLAN / AUTOMATIC ENROLLMENT

The State of West Virginia has established an Internal Revenue Code Section 457(b) Deferred Compensation Plan (Plan) for the benefit of its employees. The Plan provides that eligible employees may elect to join and become participants in the Plan (subject to the limitations established in the Plan) upon executing and filing a Participation Agreement with the State. Employees hired on or after July 1, 2007 will be automatically enrolled into the Plan and an amount equal to $10 per pay period will be deducted from your pay and deposited into an account in your name, to be invested under the Plan. If you do not want to participate in the Plan at this time, please check the "Decline Automatic Enrollment" option above and return the form to your Benefits Coordinator within 30 days of your date of employment. If you elect this option, you may choose to enroll in the Plan at a later date.

The employee acknowledges the following:

1. I elect to participate in the Plan and agree to defer compensation to the Plan in accordance with the Plan and Internal Revenue Code (Code).
2. I agree that all rights to the deferred compensation shall be governed by the terms and conditions of the Plan and Code.
3. I agree that the elections indicated above will remain in effect until later changed or revoked by me or my contributions during any year reach the maximum dollar amount allowed under the Plan and Code. If the latter occurs, my salary deferral election will automatically stop.
4. It is my responsibility to comply with any Internal Revenue Code deferral limits and that I may be responsible for any costs, including taxes and penalties that I may incur as a result of excess contributions.

TO DESIGNATE A BENEFICIARY CALL 1-800-551-4218 OR VISIT WWW.WV457.GOV

I certify that the information on this form is true, complete and accurate.

KEEP A COPY FOR YOUR RECORDS. RETURN COMPLETED FORM TO YOUR PAYROLL/BENEFITS COORDINATOR.

EMPLOYEE SIGNATURE _____ DATE _____

PAYROLL/BENEFIT COORDINATOR SIGNATURE ONLY _____ DATE _____ STATE AGENCY/POLITICAL SUBDIVISION _____

Coordinator please mail or fax a copy of this form to Office of the State Treasurer, 457 Retirement Plus, 322 70th Street, Charleston, WV 25304, Fax: 304-340-1503

Revised 4/28/2025

WV457.gov

Beneficiary Designation
Governmental 457(b) Plan

State of West Virginia Retirement Plus Deferred Compensation Plan **98947-01**

For My Information

- *For questions regarding this form, visit the website at www.wv457.com or contact Service Provider at 1-800-551-4218.*
- *Use black or blue ink when completing this form.*

A Participant Information

Account extension, if applicable, identifies funds transferred to a beneficiary due to participant's death, alternate payee due to divorce or a participant with multiple accounts.

Account Extension ______

Social Security Number *(Must provide all 9 digits)* ☐☐☐-☐☐-☐☐☐☐

Last Name ______ First Name ______ M.I. ______ Date of Birth ___/___/___

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

☐ Married ☐ Unmarried

B Beneficiary Designation *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation *(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

___ %
% of Account Balance ______ Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*

( ) ______
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

___ %
% of Account Balance ______ Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*

( ) ______
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

___ %
% of Account Balance ______ Primary Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*

( ) ______
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 Designation *(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

___ %
% of Account Balance ______ Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*

( ) ______
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

___ %
% of Account Balance ______ Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*

( ) ______
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

Last Name	First Name	M.I.	Social Security Number	98947-01 Number

B **Beneficiary Designation** *(Attach an additional sheet to name additional beneficiaries.)*

Contingent Beneficiary Designation *(Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

%	
% of Account Balance	Contingent Beneficiary Name *(Name of Individual, Trust, Charity, etc.)*
( ) 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

C **Participant Consent for Beneficiary Designation** *(Please sign on the 'Participant Signature' line below.)*

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. I acknowledge and agree that it is my responsibility to monitor the beneficiary designations in my account and to update the beneficiary designations as I deem necessary upon a change in marital status, death of a beneficiary or any other change that may impact my beneficiary designations.

If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Service Provider. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100%. The percentages can be divided up to two decimal points (Example: 33.33%).**

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature _____ **Date** ***(Required)*** _____

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

D **Delivery Instructions**

After all signatures have been obtained, this form can be

Uploaded Electronically:	**OR**	**Sent Regular Mail to:**	**OR**	**Sent Express Mail to:**
Login to account at **www.wv457.com** Click on Upload Documents to submit		Empower PO Box 173764 Denver, CO 80217-3764		Empower 8515 E. Orchard Road Greenwood Village, CO 80111

We will not accept hand delivered forms at Express Mail addresses.

This page is for informational purposes only - Do not return with the Beneficiary Designation form

EXAMPLE BENEFICIARY DESIGNATIONS

Example 1: Multiple Individuals as Beneficiaries

B **Beneficiary Designation** *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation *(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

33.33 % — % of Account Balance

John M. Doe — Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*

(XXX) XXX-XXXX — 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

33.33 % — % of Account Balance

Don M. Doe — Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*

(XXX) XXX-XXXX — 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

33.34 % — % of Account Balance

Michelle L. Doe — Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*

(XXX) XXX-XXXX — 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

Example 2: Trust as Beneficiary

B **Beneficiary Designation** *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation *(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

100 % — % of Account Balance

Trust of Jane Doe — Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*

(XXX) XXX-XXXX — 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

Example 3: Estate as Beneficiary

B **Beneficiary Designation** *(Attach an additional sheet to name additional beneficiaries.)*

Primary Beneficiary Designation *(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)*

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

100 % — % of Account Balance

Estate of Anne Doe — Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*

(XXX) XXX-XXXX — 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

This page is for informational purposes only - Do not return with the Beneficiary Designation form
EXAMPLE BENEFICIARY DESIGNATIONS

Example 4: Charity as Beneficiary

B **Beneficiary Designation** ***(Attach an additional sheet to name additional beneficiaries.)***

Primary Beneficiary Designation ***(Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)***

- See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate.

100 %
% of Account Balance

ABC Charity
Primary Beneficiary
(Name of Individual, Trust, Charity, etc.)

(XXX) XXX-XXXX
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

WV457 RETIREMENT PLUS

Participant Enrollment
Governmental 457(b) Plan

State of West Virginia Retirement Plus Deferred Compensation Plan 98947-01

Participant Information

Social Security Number

Last Name First Name MI

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

E-Mail Address

Mailing Address

City State Zip Code

( ) Home Phone ( ) Work Phone

( ) Mobile Phone

☐ Married ☐ Unmarried

☐ Female ☐ Male ☐ Nonbinary ☐ Unspecified

Mo Day Year Date of Birth

Mo Day Year Date of Hire

☐ Check box if you prefer to receive quarterly account statements in Spanish.

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

Statement Delivery - Participant quarterly statements are sent regular mail via the U.S. Postal Service. If you prefer an environmentally friendly alternative, please visit www.wv457.com for fast and easy enrollment in our Online File Cabinet service.

Payroll Center Name

Payroll Center Number

Investment Option Information (applies to all contributions) - Please refer to your communication materials 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				INVESTMENT OPTION		
%	NAME	TICKER	CODE	%	NAME	TICKER	CODE
____	T. Rowe Price Capital Appreciation I	TRAIX	TRAIX	____	American Funds Eupac R6	RERGX	RERGX
____	Capital Group 2010 Target Date Ret SA	N/A	V0647A	____	American Funds New Perspective R6	RNPGX	RNPGX
____	Capital Group 2015 Target Date Ret SA	N/A	V0650A	____	Baron Small Cap Instl	BSFIX	BSFIX
____	Capital Group 2020 Target Date Ret SA	N/A	V0653A	____	PIMCO RAE US Small Instl	PMJIX	PMJIX
____	Capital Group 2025 Target Date Ret SA	N/A	V0656A	____	Vanguard Small Cap Index Instl	VSCIX	VSCIX
____	Capital Group 2030 Target Date Ret SA	N/A	V0659A	____	American Century Mid Cap Value R6	AMDVX	AMDVX
____	Capital Group 2035 Target Date Ret SA	N/A	V0662A	____	T. Rowe Price Mid-Cap Growth I	RPTIX	RPTIX
____	Capital Group 2040 Target Date Ret SA	N/A	V0665A	____	Vanguard Mid Cap Index Ins	VMCIX	VMCIX
____	Capital Group 2045 Target Date Ret SA	N/A	V0668A	____	American Funds Fundamental Investors R6	RFNGX	RFNGX
____	Capital Group 2050 Target Date Ret SA	N/A	V0671A	____	Fidelity Contrafund	FCNTX	FCNTX
____	Capital Group 2055 Target Date Ret SA	N/A	V0674A	____	JPMorgan Equity Income R6	OIEJX	OIEJX
____	Capital Group 2060 Target Date Ret SA	N/A	V0677A	____	Vanguard Institutional Index I	VINIX	VG-IND
____	Capital Group 2065 Target Date Ret SA	N/A	V0680A	____	Vanguard Total Bond Market Index Inst	VBTIX	VBTIX
____	Capital Group 2070 Target Date Ret SA	N/A	V0683A	____	West Virginia Fixed Fund	N/A	WVFIX

= 100% MUST INDICATE WHOLE PERCENTAGES

Last Name	First Name	M.I.	Social Security Number	Number
				98947-01

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. I have the right to change the beneficiary. If any information 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.

The number of primary and contingent beneficiaries you name is not limited. If you wish to designate more beneficiaries, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.

Primary Beneficiary

% of Account Balance — Primary Beneficiary Name — 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

Primary Beneficiary

% of Account Balance — Primary Beneficiary Name — 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

Primary Beneficiary

% of Account Balance — Primary Beneficiary Name — 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

% of Account Balance — Contingent Beneficiary Name — 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

% of Account Balance — Contingent Beneficiary Name — 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

% of Account Balance — Contingent Beneficiary Name — 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

Last Name	First Name	M.I.	Social Security Number	98947-01 Number

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 to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

Investment Options - I understand that by signing and submitting this Participant Enrollment form for processing, I am requesting to have invesment 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 and I understand the risks of investing.

Compliance With Plan Document and/or the Code - I agree that my employer or Plan Administrator 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 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.

Signature(s) and Consent

Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form.

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.

After all signatures have been obtained, this form can be:

Uploaded electronically to:
Login to account at
www.wv457.com
Click on *Upload Documents* to submit

OR

Sent regular mail to:
Empower
PO Box 173764
Denver, CO 80217-3764

OR

Sent express mail to:
Empower
8515 E. Orchard Road
Greenwood Village, CO 80111

We will not accept hand delivered forms at express mail addresses.