TRANSAMERICA® Retirement Solutions

4333 Edgewood Road NE
Cedar Rapids, IA 52499

Section A: Employer Information

Enrollment Application

Company/Employer Name: **Montgomery County Deferred Compensation Plan**

☐ New Enrollment
☐ Contribution Change

Contract/Account No.: **PE61346** Affiliate No.: **00001** Division No.:

Section B: Participant Information

Social Security No. | Date of Birth (MM-DD-YYYY)

First Name/Middle Initial | Last Name

Mailing Address | State | Zip code

City | E-mail

Phone No./Ext. | Date of Hire (MM-DD-YYYY)

Marital Status ☐ Married ☐ Single/Divorced Gender ☐ Male ☐ Female

Section C: Contributions (By law, any election will not be effective until the following month, except if completed on the first day of employment or earlier.)

☐ I elect to reduce my eligible compensation by _____, each pay period as a pre-tax salary deferral contribution.

Note: You may apply the age 50 catch-up or the last three taxable years catch-up for any given calendar year.

☐ For employees who have attained age 50 (or will attain age 50 this calendar year)

☐ I elect to reduce my eligible compensation, in equal amounts each pay period as indicated below:

☐ $ _____ as a pre-tax salary deferral contribution.

☐ I am in the last three taxable years ending before the year of my normal retirement age (as defined in the plan) and have underutilized past contributions while eligible. I elect to make additional contributions in accordance with the Special 457(b) Catch-up provision. The catch-up contribution will not exceed the lesser of my underutilized limit or twice the dollar amount of the 457(b) limit allowed for the year that I elect to contribute the catch-up contribution. I elect to make a catch-up contribution:

☐ as a pretax salary deferral contribution, for the taxable year _____ of $_____ or _____%. (whole percentages)

☐ The above election(s) is effective with the payroll period beginning _____ (may not be retroactive).

☐ I elect not to make contributions to this plan.

☐ Contact me to help me consolidate another retirement plan (401K, 403B, IRA, etc) into my new Transamerica account.

Section D: Investment Allocation

Create Your Own Portfolio- Please allocate contributions to the following investment options in the percentages noted below (total must equal 100%)

Choose a Portfolio

MN20	Transamerica Asset Allocation Short Horizon R	%
MR1B	Transamerica Asset Allocation Intermed Horizon R	%
MN22	Transamerica Asset Allocation Long Horizon R	%

Create a Portfolio

MN4B	Transamerica Government Money Market R2	%
GMS5	TFLIC Managed Stability - Stable 5	%
MR5B	Transamerica High Quality Bond R	%
MN5B	Transamerica Intermediate Bond R	%
MNDC	Transamerica Inflation-Protected Securities R	%
MR6B	Transamerica High Yield Bond R	%
MN6B	Transamerica Large Value Opportunities R	%
MNAC	Transamerica Large Core R	%
MN1A	Transamerica Large Growth R	%
MR12	Transamerica International Equity R	%
MR4B	Transamerica Balanced II R	%

Section E: Signatures

I understand that any catch-up contributions elected above are not determined to be catch-up contributions until my regular pre-tax salary deferral contributions exceed an applicable limit under the plan, and that the amount of my salary reduction above may not exceed the limits of contributions set forth in my employer's plan.

Transamerica Investors Securities Corporation (TISC), 440 Mamaroneck Avenue, Harrison, NY 10528, distributes securities products. Any registered fund offered under the plan is distributed by that particular fund's associated fund family and its affiliated broker-dealer or other broker-dealers with effective selling agreements such as TISC.

I acknowledge that investment option information, including prospectuses, disclosure documents, and/or fund profile sheets, as applicable have been made available to me and I understand the risks of investing.

The Transamerica funds are distributed by Transamerica Capital, Inc. (TCI) and are advised by Transamerica Asset Management (TAM). Transamerica, TISC, TAM, and TCI are affiliated companies.I understand that the fixed interest option(s) are available under group annuity contract(s) issued by Transamerica Financial Life Insurance Company ("TFLIC") and that the mutual fund options are subject to a Custodial Agreement with State Street Bank and Trust Company ("SSBT"). I understand that the group annuity contracts are legally separate arrangements from the Custodial Agreement. SSBT has no control over or responsibility for the group annuity contracts. I understand that an annual administrative fee, a withdrawal charge, and transfer restrictions may apply.The Transamerica investment options are available under a group variable annuity contract issued by Transamerica Financial Life insurance Company ("TFLIC"), which is offered through Transamerica Investors Securities Corporation, 440 Mamaroneck Avenue, Harrison, NY 10528. I understand that an annual administrative fee, a withdrawal charge, and transfer restrictions may apply.The Stable Pooled Fund is offered through Transamerica Retirement Solutions Collective Trust and invests directly in the Wells Fargo Stable Return Fund which is a collective trust fund of Wells Fargo.

I agree to the terms of the plan. I am aware that amounts deferred under this type of plan are included in my employer's general assets. I understand that I may change the amount of my salary reduction, or terminate this agreement, by giving notice according to the terms of the plan. I understand that upon termination of my employment, my account will be distributed according to my election and according to the terms of the plan.

X _____ _____

Participant Signature Date

TRANSAMERICA®

Beneficiary Designation

INSTRUCTIONS

To designate a beneficiary or to change your existing beneficiary designation on your plan, complete all applicable sections of this form, obtain any required signatures, and return it to Kris Haag at Montgomery CountyRisk Management Department 501 N. Thompson, Suite 202, Conroe, TX 77301. Phone: 936-730-6935 Fax: 936-538-8169. If you have any questions regarding this form, please contact us at 800-755-5801.

PLAN SPONSOR INFORMATION

Plan Name	Montgomery County Deferred Compensation Plan				
Contract/Account No.	PE61346	Affiliate No.	00001	Division No.	

PERSONAL INFORMATION

Social Security No.		Date of Birth (mm/dd/yyyy)			
First Name/Middle Initial		Last Name			
Mailing Address					
City		State		Zip Code	
Phone No.		Ext.			
E-mail Address					

PRIMARY BENEFICIARY DESIGNATION - WILL RECEIVE BENEFITS IN THE EVENT OF YOUR DEATH

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole percentages and total 100%. If you do not indicate shares, benefits will be split equally among surviving beneficiaries. If the named beneficiary is a trust, please specify the name and date of the trust under Entity Name and also provide the name of the Trustee.

Note: Share of benefits must total 100% for primary beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Type of Beneficiary Designation [ ] Individual [ ] Entity

Share of Benefits _____ % (whole percentages only) Relationship _____

Social Security No. _____ Date of Birth (mm/dd/yyyy) _____

First Name/Middle Initial _____ Last Name _____

Entity Name _____

Trustee/Executor _____

Entity Tax ID _____ Effective Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

PRIMARY BENEFICIARY DESIGNATION (CONTINUED)

Type of Beneficiary Designation [ ] Individual [ ] Entity

Share of Benefits _____ % (whole percentages only) Relationship _____

Social Security No. _____ Date of Birth (mm/dd/yyyy) _____

First Name/Middle Initial _____ Last Name _____

Entity Name _____

Trustee/Executor _____

Entity Tax ID _____ Effective Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

CONTINGENT BENEFICIARY - WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS LIVING AT THE TIME OF YOUR DEATH

Note: Share of benefits must total 100% for contingent beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Type of Beneficiary Designation [ ] Individual [ ] Entity

Share of Benefits _____ % (whole percentages only) Relationship _____

Social Security No. _____ Date of Birth (mm/dd/yyyy) _____

First Name/Middle Initial _____ Last Name _____

Entity Name _____

Trustee/Executor _____

Entity Tax ID _____ Effective Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

CONTINGENT BENEFICIARY DESIGNATION (CONTINUED)

Type of Beneficiary Designation [ ] Individual [ ] Entity

Share of Benefits _____ % (whole percentages only) Relationship _____

Social Security No. _____ Date of Birth (mm/dd/yyyy) _____

First Name/Middle Initial _____ Last Name _____

Entity Name _____

Trustee/Executor _____

Entity Tax ID _____ Effective Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

PARTICIPANT SIGNATURE

I hereby warrant that all of the statements and information contained in this request/form are true in all respects. I understand that if I have made any false or misleading statements in this request that such statements could result in significant tax consequences and/or other monetary damages to the Plan, my Plan Sponsor and Transamerica. Moreover, I hereby agree to indemnify and hold (a) the Plan, (b) Transamerica, and (c) my Plan Sponsor harmless from any tax consequences and/or other monetary damages that may result in whole or in part from my false and misleading statements I certify that the information provided on this form is correct and complete.

X_____ **X**_____

Participant Signature Date

X _____ **X**_____

Print Name Social Security Number

PLAN SPONSOR SIGNATURE

I certify that the information provided on this form is correct and complete, and that any required consents and waivers have been obtained.

X_____ **X**_____

Plan Sponsor Signature Date

Supplemental Beneficiary Designations

Social Security No.

First Name/Middle Initial

Last Name

Note: Share of benefits must total 100% for primary beneficiaries *(will receive benefits in the event of your death)* **AND *100% for contingent beneficiaries*** *(will receive benefits if no primary beneficiary is living at the time of your death).*

[ ] Primary Beneficiary [ ] Contingent Beneficiary

Type of Beneficiary Designation [ ] Individual [ ] Entity

Share of Benefits % (whole percentages only) Relationship

Social Security No. Date of Birth (mm/dd/yyyy)

First Name/Middle Initial Last Name

Entity Name

Trustee/Executor

Entity Tax ID Effective Date

Mailing Address

City State Zip Code

[ ] Primary Beneficiary [ ] Contingent Beneficiary

Type of Beneficiary Designation [ ] Individual [ ] Entity

Share of Benefits % (whole percentages only) Relationship

Social Security No. Date of Birth (mm/dd/yyyy)

First Name/Middle Initial Last Name

Entity Name

Trustee/Executor

Entity Tax ID Effective Date

Mailing Address

City State Zip Code