FORM MUST BE RETURNED TO HRM

Paycheck Contribution Election
Governmental 457(b) Plan

Louisiana Public Employees Deferred Comp. Plan **98228-01**

Use black or blue ink when completing this form. For questions regarding this form, visit the Web site at www.louisianadcp.com or contact Service Provider at 1-800-937-7604.

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.

Daytime Phone Number

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

LSU HSC - NEW ORLEANS P1-D700

Division/Payroll Center

Alternate Phone Number

I have a retirement savings account with a previous employer or an IRA. ❑ Yes or ❑ No

I would like help consolidating my other retirement accounts into my account with State of Louisiana.* ❑ Yes, I would like a representative to call me at phone #_____-_____-_____ to review my options and assist me with the process. The best time to call is _____ to _____ A.M./ P.M. (circle one - available 7 a.m. to 9 p.m. Central time). *Rollovers are subject to my Plan's provisions.

B Payroll Election(s)

Paycheck Contribution Election *(Payroll Deductions)*

Select One: ❑ Start ❑ Restart ❑ Change ❑ Stop

I elect to contribute to the Plan the following of my eligible compensation indicated below *(per pay period)*:

X Before Tax Contributions $_____ or 7.5% _____% (do not complete both) (up to $20,500.00 or 1% - 100%)

❑ Roth Contributions $_____ or _____% (do not complete both) (up to $20,500.00 or 1% - 100%)

PayrollEffective Date *(mm/dd/yyyy)* _____/_____/_____ Date of Hire *(mm/dd/yyyy)* _____/_____/_____

The total annual before-tax and Roth contributions cannot exceed $20,500.00 of my eligible compensation in the 2022 tax year.

Leave Pay/Lump-Sum Pay

❑ I wish to direct all of my first 300 hours of leave pay (if available) from my last paycheck not to exceed the annual contribution limit.
Final paycheck date:_____(Form must be received the month prior to your final paycheck date.)

OR-

❑ I wish to direct $_____of leave pay from my last paycheck not to exceed the annual contribution limit.
Final paycheck date:_____(Form must be received the month prior to your final paycheck date.)

Catch-Up Election

Age 50 §457 Catch-Up:

I elect to contribute to the Plan additional Age 50 Catch-Up amounts of my eligible compensation as indicated below *(per pay period)*:

Payroll Effective Date *(mm/dd/yyyy)* _____/_____/_____

The total before-tax Age 50 Catch-Up amount cannot exceed $6,500.00 of my eligible compensation in the 2022 tax year. Only one type of §457 Catch-Up may be used in a calendar year. If I am eligible for both types of Catch-Up this year, I may select either Age 50 §457 Catch-Up or Special §457 Catch-Up, whichever would result in the larger Catch-Up amount for this calendar year. I must be age 50 or older by the end of this calendar year and I may not use the Special §457 Catch-Up this year.

❑ I elect to cancel my Catch-Up contribution election.

-OR-

Special §457 Catch-Up:

I elect to contribute to the Plan the Special §457 Catch-Up amounts of my eligible compensation as indicated below *(per pay period)*:

Payroll Effective Date *(mm/dd/yyyy)* _____/_____/_____

The total before-tax Special §457 Catch-Up amount cannot exceed $20,500.00 of my eligible compensation in the 2022 tax year. *(When added to the basic contribution amount, the aggregate maximum available is $41,000.00 in 2022.)* I may only use Special §457 Catch-Up in one or more of the three calendar years that **END PRIOR TO** Normal Retirement Age (NRA). I have designated my NRA year below. I must have "underutilized amounts" by not contributing the maximum amount available to me under this Plan in any prior calendar years in which I was eligible to participate. I have calculated the total underutilized amounts I have available for Special §457 Catch-Up using the attached Underutilized Amounts Worksheet as indicated below. The calculation tools are provided for my convenience and I should consult with my tax advisor about my tax situation.

NRA Year:_____ **Underutilized Amount: $**_____

❑ I elect to cancel my Catch-Up contribution election.

Last Name	First Name	M.I.	Social Security Number	98228-01 Number

C Signatures and Consent *(Signatures must be on the lines provided.)*

Participant Consent *(Please sign on the 'Participant Signature' line below.)*

My signature acknowledges that I have read, understand and agree to all pages of this form and affirms that all information that I have provided is true and correct. I also understand that:

- Until cancelled, superseded or I cease to be an eligible employee, all election(s) shall apply to all eligible compensation allowed by the Plan paid from the effective date specified unless a different effective date is required under the terms of the Plan and cancels all previous elections.
- Payroll elections must be entered into prior to the first day of the month that the deferral will be made.
- If I am increasing or decreasing my payroll deductions, the new deferral amount will take effect on the first pay period after the first of the month in which the change was made.
- If I am stopping payroll deductions, all existing deferrals will be cancelled.
- I may change the amount of compensation contributed as allowed under the terms of the Plan.
- 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.
- My Plan Administrator may take any action that may be necessary to ensure that my participation is in compliance with any applicable requirement of the Plan Document and the Internal Revenue Code.
- I authorize the payroll deduction as indicated on this form.

Any person who presents false or fraudulent information 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 Mailing Instructions

Participant forward this form to:

Louisiana Public Emp Def Comp Plan
9100 Bluebonnet Centre Blvd.
Suite 203
Baton Rouge, LA 70809
Fax #: 1-225-296-6832

After all signatures have been obtained, this form can be

Sent Regular Mail to:	**OR**	**Sent Express Mail to:**
State of Louisiana PO Box 173764 Denver, CO 80217-3764		State of Louisiana 8515 E. Orchard Road Greenwood Village, CO 80111

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

Quick Enrollment
Governmental 457(b) Plan

Louisiana Public Employees Deferred Comp. Plan 98228-01

Participant Information

Yes! I would like to enroll in the Louisiana Public Employees Deferred Comp. Plan and voluntarily contribute:

- ❑ $_____ or 7.5 % per pay period of my eligible compensation on a **Before Tax** basis.
- ❑ $_____ or _____% per pay period of my eligible compensation on a **Roth** basis.
- ❑ I do not wish to contribute to the Plan at this time.

Last Name | First Name | MI

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

Address - Number & Street

City | State | Zip Code

( ) Home Phone ( ) Work Phone

LSU HSC - NEW ORLEANS P1/D700
Employer / Agency Name

Social Security Number

E-Mail Address

❑ Married ❑ Unmarried ❑ Female ❑ Male

Mo Day Year — Date of Birth

Mo Day Year — Date of Hire

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

Investment Option: I understand that this form is my election to enroll in the Plan. By signing this form, my contributions will be allocated to the Plan's default investment fund without additional action by me. If I wish to contribute to any of the investment options of the Plan other than the default fund, I understand that I must contact my Plan Administrator or local representative to obtain a Participant Enrollment Form. The Plan has selected a TARGET DATE portfolio of funds as its default investment fund. Until such time as you choose investment options for your Plan account, your contributions will be invested in the fund within this portfolio that most closely corresponds to certain factors in your profile. For more information, please contact your GWRS Representative. I acknowledge that information about Plan investment options, including prospectuses, disclosure document and Fund Data sheets are available to me through my Plan Administrator or Plan Web site. I understand the risks of investing and that all payments and account values may not be guaranteed and may fluctuate in value.

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 understand that I have the right to direct the investment of my account and that I can change my investment allocation from the Plan's default fund at any time by logging on to my account at www.louisianadcp.com or by calling the Voice Response System at 1-800-937-7604. *A personal identification number (PIN) that gives you access to your account via the Web or phone will be mailed to you soon after your application is processed. You are responsible for keeping the assigned PIN confidential. Please contact us if you suspect unauthorized use.*

My Account: 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 from 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 the notification forward and not on a retroactive basis.

Beneficiary Designation: I understand that I must choose a beneficiary of my account with this Plan by filing a separate Beneficiary Designation form with the Service Provider.

Required Signature - By signing this form, I verify that this enrollment was unsolicited. I also acknowledge that I have previously received detailed information about this Plan from my employer and understand that my participation in the Plan must be in compliance with the Plan Document and/or the Internal Revenue Code. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx. Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

X _____ _____
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.

Participant Fax to: 1-866-745-5766 (or) Mail to: Empower Retirement
Phone: 1-800-937-7604 PO Box 173764 Denver, CO 80217-3764

Beneficiary Designation
Governmental 457(b) Plan

Louisiana Public Employees Deferred Comp. Plan **98228-01**

For My Information

- *For questions regarding this form, visit the website at www.louisianadcp.com or contact Service Provider at 1-800-937-7604.*
- *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. ____

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

Date of Birth ___ / ___ / ___

Daytime Phone Number ( ) ____________

Email Address ____________

Alternate Phone Number ( ) ____________

❑ 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.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date ___ / ___ / ___

Street Address | City | State | Zip Code

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.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date ___ / ___ / ___

Street Address | City | State | Zip Code

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.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date ___ / ___ / ___

Street Address | City | State | Zip Code

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.)* | Social Security or Taxpayer Identification Number | Date of Birth or Trust Date ___ / ___ / ___

Street Address | City | State | Zip Code

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	98228-01 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.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
%			/ /

Street Address	City	State	Zip Code
( ) 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.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
%			/ /

Street Address	City	State	Zip Code
( ) 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%).**

I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

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:
Login to account at
www.louisianadcp.com
Click on Upload Documents to submit

OR

Sent Regular Mail to:
State of Louisiana
PO Box 173764
Denver, CO 80217-3764

OR

Sent Express Mail to:
State of Louisiana
8515 E. Orchard Road
Greenwood Village, CO 80111

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

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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 %	John M. Doe	XXX-XX-XXXX	01/06/1954
% of Account Balance	Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
111 Elm Street	Anytown	MO	60000
Street Address	City	State	Zip Code
(XXX) XXX-XXXX	Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*		
Phone Number *(Optional)*	❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ■ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner		

33.33 %	Don M. Doe	XXX-XX-XXXX	01/06/1954
% of Account Balance	Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
222 North Avenue	Anytown	CA	90000
Street Address	City	State	Zip Code
(XXX) XXX-XXXX	Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*		
Phone Number *(Optional)*	❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ■ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner		

33.34 %	Michelle L. Doe	XXX-XX-XXXX	01/06/1957
% of Account Balance	Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
333 West Blvd	Anytown	CO	80000
Street Address	City	State	Zip Code
(XXX) XXX-XXXX	Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*		
Phone Number *(Optional)*	❑ 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 %	Trust of Jane Doe	XX-XXXXXXX	06/30/2015
% of Account Balance	Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
150 Main Street	Anytown	MO	60000
Street Address	City	State	Zip Code
(XXX) XXX-XXXX	Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*		
Phone Number *(Optional)*	❑ 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 %	Estate of Anne Doe		/ /
% of Account Balance	Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
45 East Road	Anytown	MO	60000
Street Address	City	State	Zip Code
(XXX) XXX-XXXX	Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*		
Phone Number *(Optional)*	❑ 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 %	ABC Charity	XX-XXXXXXX	/ /
% of Account Balance	Primary Beneficiary *(Name of Individual, Trust, Charity, etc.)*	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
75 South Place	Anytown	CO	80000
Street Address	City	State	Zip Code

(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