Check if new participant Check if change to existing allocations Catch-up contribution eligibility I will be age 50 or older this calendar year. Employee Information Name Telephone # () SSN	Brown Local School		US OMNI&TSACG Compliance Services				
City State S	457(b) Participation Agreement Check if new participant					Compliance Services	
In the large 50 or older this calendar year.	Check if change to existing allo	cations					
Mailing Address		lendar year.					
Mailing Address	Employee Information						
Employer Name	Name		Telephone # ()		SSN		
Employer Name	Mailing Address				Date of	Hire	
Salary Reduction The undersigned hereby agrees to the terms and conditions of the , Deferred Compensation Plan ("Plan") as such Plan now exists or is here in after amended and a copy of the Plan has been made available to them. This election shall continue until the undersigned makes a subsequent election as provided by the Plan. The hereby authorizes on the provider company to issue a annuity contract or custodial arrangement for the benefit of the particulation that without the signature of the employer provided that the owner of the annual contract or custodial arrangement is designed as the employer's 457 Deferred Compensation Plan. Subject to the annual contribution limits and other requirements of the 457(b) Plan of the Employer to reduce on read noncontribution under the Plan. The amount of such reduction and payment shall be as follows: \$\frac{1}{2}\$ per period. This participation agreement will superceal previous 457(b) participation agreement elections under the Plan. Thereby authorize my employer to reduce or suspend any deferrals established by this agreement, if in its opinion, the total annual deferral would exceed the maximum allowable limit any calendar year. Allocation of Contributions My deferrals cannot begin sooner than the month following participation agreement approval. My accumulated deferrals will be held in trust by the , for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the Plan. I realize I may not assign or transfer my rights under the Plan. Please indicate ALL of the annualy contracts or custodial accounts to which salary reduction contributions should be allocated. Allocations itsed below will supersed all previous allocations for salary reduction contributions. Allocations will be satisfied in the order listed below will supersed allocated to the last account listed. Allocations may only be made to an annualy contract or custodial account that is approved for use with the Plan. Provider and Allocation Information Provider Nam	City	_ State	Zip	Date of Birth	E-mail		
Salary Reduction The undersigned hereby agrees to the terms and conditions of the , Deferred Compensation Plan ("Plan") as such Plan now exists or is here in after amended and a copy of the Plan has been made available to them. This election shall continue until the undersigned makes a subsequent election as provided by the Plan. The hereby authorizes on the provider company to issue a annuity contract or custodial arrangement for the benefit of the particulation that without the signature of the employer provided that the owner of the annual contract or custodial arrangement is designed as the employer's 457 Deferred Compensation Plan. Subject to the annual contribution limits and other requirements of the 457(b) Plan of the Employer to reduce on read noncontribution under the Plan. The amount of such reduction and payment shall be as follows: \$\frac{1}{2}\$ per period. This participation agreement will superceal previous 457(b) participation agreement elections under the Plan. Thereby authorize my employer to reduce or suspend any deferrals established by this agreement, if in its opinion, the total annual deferral would exceed the maximum allowable limit any calendar year. Allocation of Contributions My deferrals cannot begin sooner than the month following participation agreement approval. My accumulated deferrals will be held in trust by the , for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the Plan. I realize I may not assign or transfer my rights under the Plan. Please indicate ALL of the annualy contracts or custodial accounts to which salary reduction contributions should be allocated. Allocations itsed below will supersed all previous allocations for salary reduction contributions. Allocations will be satisfied in the order listed below will supersed allocated to the last account listed. Allocations may only be made to an annualy contract or custodial account that is approved for use with the Plan. Provider and Allocation Information Provider Nam	Employer Name		C	City	Sta	te	
Product Provider Name Address for Premium Remittance EE or ER Contribution Policy Number Amounts \$ \$ (Total includes EE salary deferrals and ER contributions) Total per Pay Period \$ Effective Date and Duration The Salary Reduction and Allocation Agreement shall take effect: As soon as permitted under the Plan and as soon as administratively feasible; or Not before // 20 // 120 // 170 /	Salary Reduction The undersigned hereby agrees to copy of the Plan has been made a hereby authorizes on the provider of provided that the owner of the and contribution limits and other require payment of an equal amount for dereduction and payment shall be as agreement elections under the P the total annual deferral would exallocation of Contribution My deferrals cannot begin soone exclusive benefit of participants and Please indicate ALL of the annuit supersede all previous allocation.	the terms and conditions of available to them. This electrompany to issue a annuity fully contract or custodial ments of the 457(b) Plan aposit to a qualified annuity follows: \$	of the , Deferred Compection shall continue up a contract or custodial arrangement is design of the Employer, I autity contract or custodial per pay period. Truy employer to reduce wable limit in any calculation agreement to me under the laccounts to which sall partributions. Allocation	pensation Plan ("Plan") as such ntil the undersigned makes a sarrangement for the benefit of the ned as the employer's 457 Denorize the Employer to reduce relaccount as a salary reduction his participation agreement were or suspend any deferrals condar year. Deement approval. My accumulates of the Plan. I realize I may reduction contributions should be satisfied in the order I	Plan now exists or is subsequent election are participant without ferred Compensation and contribution under the vill supercede all pestablished by this atted deferrals will be a y not assign or transpuld be allocated. A sisted below with any	s here in after amended and a as provided by the Plan. The the signature of the employer n Plan. Subject to the annual on in exchange for the prompt the Plan. The amount of such arevious 457(b) participation agreement, if in its opinion, the held in trust by the , for the sfer my rights under the Plan.	
Effective Date and Duration S S S S S S S S S	Provider and Allocation	Information					
Effective Date and Duration The Salary Reduction and Allocation Agreement shall take effect: As soon as permitted under the Plan and as soon as administratively feasible; or Not before I / 20	Product Provider Name	Address for Prem	ium Remittance	EE or ER Contribution	Policy Number		
Effective Date and Duration The Salary Reduction and Allocation Agreement shall take effect: As soon as permitted under the Plan and as soon as administratively feasible; or Not before							
Effective Date and Duration The Salary Reduction and Allocation Agreement shall take effect: Not before 1 120 This agreement will remain in effect as long as I remain an eligible employee under the Plan, or until I provide the Employer with a written request to end my salary reduction contributions or submit a new Salary Reduction and Allocation Agreement, as permitted under the Plan. Designation of Beneficiary The beneficiary for each annuity contract or certified account to which contributions are allocated shall be determined in accordance with the terms of that specific contract or account. Release of Liability The Employee agrees that the Employer and its agents shall have no liability whatsoever for any and all losses suffered by me with regard to my selection of the annuity and/or custodial account, its terms, the selection of the insurance company, custodian, or regulated investment company, the financial condition, operation of or benefits provided by said insurance company, custodian, or regulated investment company, or my selection and purchase of shares of regulated investment companies. The employer hereby authorizes on the provider company to issue a annuity contract or custodial arrangement for the benefit of the participant without the signature of the employer provided that the owner of the annuity contract or custodial arrangement is designated as the employer's 457 Deferred Compensation Plan.						· ·	
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Employee Signature Date (mm/dd/hoss) Employee Name (Please Print)	or benefits provided by said insuracompanies. The employer hereby authorizes on	nce company, custodian the provider company to	or regulated investm	ent company, or my selection ct or custodial arrangement for	and purchase of sh	nares of regulated investment articipant without the signature	
EMBINOVER SIGNATURE LIAIR IMPRINTAL LIAIR LI	Fundama Circutum	-			Employee Name (Plans Br. 1)		

Date (mm/dd/yyyy)

VER 12.21.2022

Employer Authorized Signature (if required)