PARTICIPATION AGREEMENT FOR SECTION 457 DEFERRED COMPENSATION PLAN

NAME (PRINT LAST, FIRST, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP CODE
DEPARTMENT	WK. PHONE	HOME PHONE	
EMPLOYEE NUMBER			

CONTRIBUTIONAMOUNT

I wish to participate in the California Medical Association Deferred Compensation Plan.

I hereby agree to defer compensation **each pay period** in the amount of $_____ **Pre-tax** /

This is to be effective on pay date_____.

INVESTMENT SELECTION

The compensation deferred is to be directed to Voya Life Insurance and Annuity Company and invested in accordance with my investment designation with that provider.

BENEFICIARY

I wish to designate the following beneficiary(ies) to receive benefits in the event of my death. I understand that each beneficiary eligible to receive benefits will receive an equal share of benefits under the Plan unless otherwise indicated.

Primary Beneficiary(ies) & relationship to participant :

_____

_____

Contingent Beneficiary(ies) & relationship to partcipant:

CATCH-UP ELECTION

☐ Three Years Prior to Normal Retirement Age

For purposes of using the catch up provision available for participants for the three years prior to the year of attainment of normal retirement age, I hereby elect a normal retirement age of _____and elect to use catch up for the calendar year periods beginning January_____ and ending December _____ understand that this catch-up election may be made only one time and that this catch-up is only available to the extent of any underutilized prior year deferrals.

REQUIRED SIGNATURES

I have read and acknowledge the above provisions and those contained in this Agreement. I understand that my elections above will remain effective until later changed or revoked.

Distributions are allowed only upon my retirement, severance from employment, death, or incurring an unforeseeable emergency.

_____ _____

Participant Signature *Date*