

OBRA/PST Acknowledgement Card
(Please complete and submit to your Payroll Center)

Plan Information

Employer Name: Town of Brimfield
Employer Plan Number: 35292-002
Employer's Phone Number: (413) 245-4100 X120

Deferral Amount*	Payroll Frequency
<u>7.5</u> %	<u>Biweekly</u>

*Contributions to the OBRA Plan must be a minimum of 7.5% of compensation.

Allocation: **100% Nationwide Fixed Account**

Participant Information

Name: _____
Mailing Address: _____

City, State, & Zip Code: _____
SS#: _____ Date of Birth: _____
Contact Phone: _____ Gender (check one):
☐ M ☐ F
Email: _____

Beneficiary Information

*If there are additional beneficiaries, please attach a separate sheet.

Primary Beneficiary

Name: _____
Address: _____
City, State, & Zip Code: _____
SSN: _____ Date of Birth: _____
Relationship: _____

Contingent Beneficiary

Name: _____
Address: _____
City, State, & Zip Code: _____
SSN: _____ Date of Birth: _____
Relationship: _____

I acknowledge and understand that my participation in the plan is governed by the Plan Document and the Informational Sheet. I understand that 100% of my deferrals will be deposited in the Nationwide Fixed Account held with Nationwide Life Insurance Company.

Participant Signature

Date

Retirement Specialist

Agent #