



CERF

COUNTY EMPLOYEES' RETIREMENT FUND

### Incoming Transfer/Direct Rollover Governmental 457(b) Plan

Do not complete the Investment Option Information portion of this form if you elected to have your account professionally managed by Advised Assets Group, LLC ("AAG").

### CERF Savings Plan - 457 Plan

98993-01

#### Participant Information

\_\_\_\_\_  
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

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
E-Mail Address

Mo Day Year  Female  Male  
Date of Birth  Married  Unmarried

#### Payroll Information

\_\_\_\_\_  
Division Name

\_\_\_\_\_  
Division Number

\_\_\_\_\_  
Location Name

\_\_\_\_\_  
Location Number

#### Transfer/Direct Rollover Information

Current Plan Administrator must authorize by signing in the Required Signature(s) section.

I am choosing a:

- Transfer from a governmental 457(b) plan.
- Direct Rollover from a governmental 457(b) plan.

#### Previous Provider Information:

\_\_\_\_\_  
Company Name Account Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City/State/Zip Code Phone Number

#### Previous Provider must complete:

Employer/employee before-tax earnings and contributions: \$ \_\_\_\_\_

Note: Unless otherwise indicated, all amounts received will be considered employee before-tax contributions and earnings.

Amount of Transfer/Direct Rollover: \$ \_\_\_\_\_ (Enter approximate amount if exact amount is not known.)

#### Investment Option Information - Please refer to your communication materials for investment option designations.

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 will refer to the fund's prospectus and/or disclosure documents for more information.

Select either existing ongoing allocations (A) or your own investment options (B).

#### (A) Existing Ongoing Allocations

- I wish to allocate this transfer/rollover the same as my existing ongoing allocations.

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M.I.

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Number

**(B) Select Your Own Investment Options**

**Please Note: For automatic dollar cost averaging call the Voice Response System or access our Web site.**

INVESTMENT OPTION				INVESTMENT OPTION			
NAME	TICKER	CODE	%	NAME	TICKER	CODE	%
Vanguard Target Retirement 2015 Inv.....	VTXVX	VTXVX	_____	Jackson Square SMID-Cap Growth CIT M.....	N/A	DELCIT	_____
Vanguard Target Retirement 2025 Inv.....	VTTVX	VTTVX	_____	Diamond Hill Small-Mid Cap Y.....	DHMYX	DHMYX	_____
Vanguard Target Retirement 2035 Inv.....	VTTHX	VTTHX	_____	American Funds American Mutual R6.....	RMFGX	RMFGX	_____
Vanguard Target Retirement 2045 Inv.....	VTIVX	VTIVX	_____	MFS Massachusetts Investors Gr Stk R6.....	MIGNX	MIGNX	_____
Vanguard Target Retirement 2055 Inv.....	VFFVX	VFFVX	_____	Vanguard Large Cap Index Adm.....	VLCAX	VLCAX	_____
Vanguard Target Retirement 2065 Inv.....	VLXVX	VLXVX	_____	Janus Henderson Balanced N.....	JABNX	JABNX	_____
American Funds EuroPacific Gr R6.....	REGRX	REGRX	_____	Pioneer Strategic Income K.....	STRKX	STRKX	_____
Invesco Global R6.....	OGLIX	OGLIX	_____	Great-West Portfolio Fund.....	PORT	PORT	_____
Vanguard Total Intl Stock Index Admiral.....	VTIAX	VTIAX	_____	<b>MUST INDICATE WHOLE PERCENTAGES</b>			<b>= 100%</b>
Vanguard Small Cap Index Adm.....	VSMAX	VSMAX	_____				

**Participant Acknowledgements**

**Advised Assets Group, LLC** - If I have elected to have my account professionally managed by Advised Assets Group, LLC and this form is submitted, my election to have my account professionally managed will override the investment allocation requested on this form until such time as I revoke or amend my election to have my account professionally managed.

**General Information** - I understand that only certain types of distributions are eligible for transfer/rollover treatment and that it is solely my responsibility to ensure such eligibility. By signing below, I affirm that the funds I am transferring/rolling are in fact eligible for such treatment.

I authorize these funds to be transferred into my employer's Plan and to be invested according to the information specified in the Investment Option Information section.

If the investment option information is missing or incomplete, I authorize Service Provider to allocate the transfer/direct rollover assets ("assets") the same as my ongoing contributions (if I have an account established) or to the default investment option selected by my Plan (if I do not have an account established). If no default investment option is selected, the funds will be returned to the payor as required by law. If my assets are received more than 180 calendar days after Service Provider receives this Incoming Transfer/Direct Rollover form (this "form"), I authorize Service Provider to allocate all monies received the same as my ongoing allocation election on file with Service Provider. I understand I must call the Voice Response System or access the Web site in order to make changes or transfer monies from the default investment option. The assets will be processed on the day this form is received. I understand that this completed form must be received by Service Provider at the address below.

I understand that the current Custodian/Provider may require that I furnish additional information before processing the transaction requested on this form, and Service Provider is not responsible for determining the status of any transaction that I have requested. It is entirely my responsibility to provide the current Custodian/Provider with any information that they may require, and/or to notify Service Provider of any information that the current Custodian/Provider may wish to obtain in order to effect the transaction.

**Withdrawal Restrictions** - I understand that the Internal Revenue Code and/or my employer's Plan Document may impose restrictions on transfers, direct rollovers and/or distributions. I understand that I must contact the Plan Administrator/Trustee, if applicable, to determine when and/or under what circumstances I am eligible to receive distributions or make transfers/direct rollovers.

**Investment Options** - I understand that by signing and submitting this form for processing, I am requesting to have investment options established under the Plan as specified in the Investment Option Information section. I understand and agree that this account is subject to the terms of the Plan Document. I understand and acknowledge that all payments and account values, when based on the experience of the investment options, may not be guaranteed and may fluctuate, and, upon redemption, shares may be worth more or less than their original cost. I acknowledge that investment option information, including prospectuses, disclosure documents and Fund Profile sheets, have been made available to me and I understand the risks of investing.

**Account Corrections** - 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 of 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 notification forward and not on a retroactive basis.

Last Name

First Name

M.I.

Social Security Number

Number

**Payment Instructions****Make check payable to:**

GREAT-WEST TRUST COMPANY, LLC

**Include the following information on the check:**Participant Name, Social Security Number,  
Plan Number, Plan Name**Wire instructions:****Bank:** US Bank**Account of:** Great-West Trust Company, LLC**Account no:** 103655774323**Routing transit no:** 102000021**Attention:** Financial Control**Reference:** Participant Name, Social Security Number,  
Plan Number, Plan Name**Regular mail address for the check and form  
(if mailed together):**GREAT-WEST TRUST COMPANY, LLC  
PO Box 560877  
Denver, CO 80256-0877**Overnight mail address for the check and form  
(if mailed together):**US Bank  
10035 East 40th Avenue Suite 100  
Attn Lockbox # 560877 DN-CO-OCLB  
Denver, CO 80238**Contact:** Empower Retirement**Phone #:** 1-800-701-8255

**If sending the "form" only**, please fax to 1-866-745-5766 or follow the mailing instructions above. Please remember that this form needs to arrive prior to or at the same time the funds arrive to invest according to the allocations on this form. We will not accept hand delivered forms at Express Mail addresses.

**Required Signature(s) and Date**

## Participant Consent

My signature indicates that I have read, understand the effect of my election and agree to all pages of this Incoming Transfer/Direct Rollover form. I affirm that all information provided is true and correct. 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>.

**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** forward to Plan Administrator

## Authorized Plan Administrator Approval

I acknowledge and agree that the Plan Administrator for the Previous Employer's Plan is released from and the Plan Administrator for the Current Employer's Plan shall assume all obligations associated with any amounts transferred under this Incoming Transfer/Direct Rollover form.

**Authorized Plan Administrator Signature  
for Current Employer's Plan****Date**

*A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.*

**Print Full Name**

**Plan Administrator** forward or fax as shown above  
in the Payment Instructions section

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