



**CONFIDENTIAL
PLANNING**

Dear Participant:

Thank you for your interest in the SmartChoice™ 403(b) plan.

1. Please complete the information requested on the enclosed SmartChoice 403(b) New Participant Enrollment form.
2. Remember to select your primary and contingent beneficiaries.
3. Sign and date.
4. Choose your investment selections making sure your selections total 100%.
5. Sign and date.
6. If your school uses The OMNI Group to oversee your school's 403(b) plan please complete the attached Salary Reduction Agreement.
7. Return the forms to us by FAX: (315) 251-0042 or by mail to:

Confidential Planning
507 Plum St Ste 120
Syracuse, NY 13204

**Participant Enrollment/Investment Election Form
Smartchoice Multi-Choice Plan [544812]**

PARTICIPANT INFORMATION: (Please Print Information Clearly)

Employee Name: _____ Date of Birth: ____/____/____

Street: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Hire: ____/____/____ Married: _____ Single: _____

CONTRIBUTION ELECTION

Elective Deferrals

- I elect to participate and contribute _____% or \$_____ of compensation per pay period on a *pre-tax* basis. (Maximum for all accounts – pre-tax and Roth after-tax contributions: \$17,500 for 2013)
- I elect to participate and contribute _____% or \$_____ of compensation per pay period to a *Roth account*. (Maximum for all accounts – pre-tax and Roth after-tax contributions: \$17,500 for 2013)
- I elect not to make *elective deferrals* until further notice. I understand that if I do not participate now, or discontinue participation, I must wait until the next available enrollment date.

Catch-up Contributions

NOTE: If you will be 50 years old or older as of the last day of the calendar year and otherwise contribute the maximum allowable amount to the Plan, you are entitled to make additional "catch-up" contributions of up to \$5,500 for 2013. See the Plan Administrator for more details on how to make these catch-up contributions.

INVESTMENT ELECTION

I authorize all contributions to be invested as follows:

	Ticker	Investment Category	New Contributions
American Funds EuroPacific Growth Fund (R4)	RREX	EQUITY	____%
American Funds SMALLCAP World Fund (R4)	RSLEX	EQUITY	____%
Vanguard Small-Cap Index Fund (Inv)	NAESX	EQUITY	____%
Vanguard Mid-Cap Index Fund (Inv)	VIMSX	EQUITY	____%
American Funds Growth Fund of America (R4)	RGAEX	EQUITY	____%
American Funds Fundamental Investors (R4)	RFNEX	EQUITY	____%
Vanguard 500 Index Fund (Inv)	VFIX	EQUITY	____%
Oppenheimer Select Value Fund (A)	OSVAX	EQUITY	____%
American Funds Income Fund of America (R4)	RIDEX	BALANCED	____%
T. Rowe Price Retirement 2050 Fund	TRRMX	BALANCED	____%
T. Rowe Price Retirement 2040 Fund	TRRDY	BALANCED	____%
T. Rowe Price Retirement 2030 Fund	TRRCX	BALANCED	____%
T. Rowe Price Retirement 2020 Fund	TRRBX	BALANCED	____%
T. Rowe Price Retirement 2010 Fund	TRRAX	BALANCED	____%
Oppenheimer International Bond Fund (A)	OIBAX	BOND	____%
Oppenheimer Senior Floating Rate Fund (A)	OOSAX	BOND	____%
Loomis Sayles Strategic Income Fund (A)	NEFZX	BOND	____%
PIMCO Total Return Fund (I)	PTTRX	BOND	____%
Lord Abbett Short Duration Income Fund (A)	LALDX	BOND	____%
Vanguard Intermed Term Treasury Fund (Inv)	VFITX	BOND	____%
Federated Prime Cash Obligations Fund (Svc)	PRCXX	CASII STABLE VALUE	____%
Must indicate whole percentages and total 100%			100%

If no funds are selected, all contributions will be allocated to a default fund selected by the Plan based on your year of birth, as listed below, until your investment elections are received.

Investment Option Name	Start Year - End Year
T. Rowe Price Retirement 2010 Fund	Before 12/31/1950
T. Rowe Price Retirement 2020 Fund	01/01/1951 - 12/31/1960
T. Rowe Price Retirement 2030 Fund	01/01/1961 - 12/31/1970
T. Rowe Price Retirement 2040 Fund	01/01/1971 - 12/31/1980
T. Rowe Price Retirement 2050 Fund	After 01/01/1981

SIGNATURES

Participant's Signature _____

Date _____

For more information on your Plan, you can call the Voice Response System at 800-530-1272 or access the Internet site at www.bpas.com. You can also speak directly to a Customer Service Representative about your Plan by calling 866-401-5272, Monday-Friday, 8:30am-6:30pm EST.

BENEFICIARY ELECTION FORM



Your Personal Information				
Participant Name		Social Security #		
Street Address				
City		State		Zip
Employer				
Plan Name				

Your Marital Status

Please check one of the three following boxes below and name primary and secondary beneficiaries:

- A. I am not married. I designate the following person(s) to receive my death benefits, if any, from the plan. If I become married, this form automatically ceases to apply and I should file a new Beneficiary Election Form.
- B. I am married, and I designate my spouse named below as sole primary beneficiary to receive my death benefits, if any, from the plan. If I re-marry, I will need to fill out a new form to designate my new spouse to receive my death benefits, if any, from the plan
- C. I am married, and I wish to designate someone other than my spouse as a primary beneficiary to receive my death benefits, if any, from the plan. *You MUST Complete Election to Waive the Pre-Retirement Survivor Benefit.*

Primary Beneficiaries			
Name			
Address			
Relationship			
Date of Birth			
Social Security #			
% Of Share			

Secondary Beneficiaries			
Name			
Address			
Relationship			
Date of Birth			
Social Security #			
% Of Share			

If I have designated more than one Primary Beneficiary, the said amount(s) shall be equally divided among my Primary Beneficiaries who are living at the time of my death unless I specify otherwise on this form. If, upon my death, there is no Primary Beneficiary living, and if I have named more than one Secondary Beneficiary, the said amount(s) shall be equally divided among my Contingent Beneficiaries who are living at the time of my death unless I specify otherwise on this form. The execution of this form and delivery thereof to the Plan Administrator revokes all prior designations of Beneficiaries that I may have made.

Signature _____

Date _____

403(b) SALARY REDUCTION AGREEMENT FORM (SRA) For Tax Sheltered Annuities and Custodial Accounts

- Please supply the information requested below.
- Read all agreements on this form before submitting.
- Fields having an asterisk notation are required.

403(b)

IMPORTANT NOTICE: Before You Sign, Read All Information on this form:

A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed \$18,000 (\$24,000 if age 50 or over). Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information

Please check here if you have contributed to another 403(b) or 401(k) plan with another employer this calendar year. If so, please provide the amount of the year-to-date contributions you have made to the other employer's plan: \$ _____ and the name of the other employer: _____

* Social Security Number: _____ * First Name: _____ MI: _____ * Last Name: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Date of Birth: _____ * Phone: _____ * Email address: _____

Part 2: Employer Information

* Full Organization Name, City and State: _____ * Date of Hire: (mm/dd/yyyy) _____

Part 3: Contribution Information

OPTION 1: Recurring Contributions

WARNING!!! Any new recurring contributions will supercede all current recurring contributions to your employer's 403(b) plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 403(b) plan, please be sure to list all contributions you wish to continue. Any active 403(b) contributions found in our records, but not listed below WILL BE DISCONTINUED.

Also, a contribution may be discontinued by listing it below with an amount of zero.

Please withhold funds from my pay for the following 403(b) contributions until further notice:

Plan Type	Service Provider	Account #	Effective Date	Amount Per Pay	OR	Percent Per Pay Period
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____

If you have requested a percentage amount for any of the contributions above, please supply:

Your Annual Salary: _____ Number of Pay Periods Per Year: _____

Please check here if you are NOT a full-time employee

OPTION 2: One-Time Contributions (Elective Contributions Only)

After this contribution, any 403(b) recurring contributions to this service provider should be:

Plan Type	Service Provider	Account #	Effective Date	Amount	
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED

Please check here if you are NOT a full-time employee

OPTION 3: Participation Opt Out

I do not wish to participate at this time. I understand that I may participate in the future simply by filling out a new Salary Reduction Agreement form.

Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.
(b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.
(c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.
(d) (i) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of any service provider, the financial condition, operation of or benefits provided by said service provider, or his/her selection and purchase of shares by any service provider. Nothing herein shall affect the terms of employment between Employer and Employee.
(ii) Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein.
(iii) The Employer shall not have any liability for any and all losses suffered by an Employee with regard to the selection(s) of any TSA and/or CA, any related terms and conditions, the selection of any service provider, the financial condition, operation of or benefits provided by any service provider or the selection and purchase of shares by any service provider.
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA.
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
10. To contact OMNI and complete the appropriate OMNI forms for any requests for distributions, loans, hardship withdrawals, account exchanges plan-to-plan transfers or rollover contributions. Processing fees for the foregoing transactions may apply.
11. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers.
12. This agreement supercedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my requested salary reduction(s), if in excess of my base limit, represent(s) my wish to utilize any catch-up provisions for which I may be eligible. I further certify that my salary reductions do not exceed contribution limits as determined by applicable law. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: _____

Date: _____

Part 6: Acknowledgement and Representation of Sales Agent/Representative (If Applicable)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. A calculation of maximum allowance will be provided annually for Employee contributing more than \$18,000 (\$24,000 if over 50) or utilizing the "catch-up provisions". Furthermore, my employer (name) _____ agrees to indemnify and hold harmless the Employer, any individual member of the governing board and the Employee participating in the 403(b) Program against any claims based on an error in the MAC I provided, except where the error is based upon erroneous information provided by Employer or Employee. Additionally, I will notify OMNI regarding any distributions or loans to participants.

Sales Agent/Representative Name: _____

Phone: _____

Email: _____

Signature: _____

Date: _____

I wish the above named agent to be copied on all e-mail communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction.

Part 7: Employer Acknowledgement (If Applicable)

Salary: _____

of TSA/CA Pay Periods: _____

Effective Payroll Date: _____

Employer Name & Title: _____

Employer Signature: _____

Date: _____

Please return this agreement to The OMNI Group, unless otherwise advised by your employer:

The OMNI Group
Water Tower Park • 1099 Jay Street, Building F • Rochester, NY 14611
Toll Free: (877) 544-OMNI • Fax: (585) 672-6194
Please visit our website at www.omni403b.com

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ACCEPTANCE LETTER and ROLLOVER/TRANSFER VERIFICATION REQUEST FORM

Receiving Plan & Plan Number _____

Participant Name _____

Soc Sec Number _____ Phone Number _____

Section A. Participant Instructions:

- 1 Contact your current account holder to initiate the rollover/transfer of your account to BPA-Harbridge
2 Complete and forward the Verification Request Form to the prior account holder along with the paperwork they may have requested you to complete
3 The check should be made payable to the plan you are rolling/transferring to including FBO your name For example XYZ Corp Retirement Plan FBO John Doe
4 Check received by BPA-Harbridge cannot be invested without receipt by BPA-Harbridge of a completed Verification Request Form
5 If the check hasn't arrived within 90 days of your signature on this form, you will be required to complete a new Verification Request Form

Section B. Participant Request

Please complete the following and sign where indicated

- 1 Plan Name and Account Number of Former Plan/Account

I am requesting that _____ (enter percentage or \$ amount) be liquidated/surrendered from this account and rolled/transferred to the above referenced receiving plan

- 2 I certify that the funds distributed for rollover/transfer from the above referenced account represent an eligible rollover/transfer and originated from (Please check one item below)

- [] A rollover from a plan qualified under IRS Code Section 401(a), 401(k), 403(b) or 457 (Governmental 457 Plans)

Total of Post-tax contributions included in rollover amount _____

Total Roth contributions _____ Date of first Roth Deferral _____

- [] A rollover from an IRA and includes no post-tax or non-deductible contributions; or a SIMPLE IRA held for more than two years (Roth IRAs and post-tax or non-deductible IRA contributions are not eligible for rollover/transfer into the receiving plan)

- [] A contract exchange from a 403(b)(1), 403(b)(7), or 403(b)(9) account to another 403(b)(1), 403(b)(7), or 403(b)(9) account (Please note the prior account holder must provide a breakdown of pre 1986, pre 1988 balances in order to track grandfathered balances for current withdrawal advantages and minimum distributions)

Total of Post-tax contributions included in transfer amount _____

Total Roth contributions _____ Date of first Roth Deferral _____

Plan Representative/Participant Signature

Date of Signature

PLEASE FORWARD THIS FORM AND THE ROLLOVER/TRANSFER CHECK TO

BPA-HARBRIDGE
6 RHODS DRIVE SUITE 7
UTICA, NY 13502

Section C Statement of Acceptance:
Community Bank, NA has agreed to serve as Custodian/Trustee/Directed Trustee for the above referenced plan and will accept a rollover/transfer provided the above certification is properly made

[Signature]
Trust Officer, Community Bank, NA

If you would like to wire funds, please use the following wiring instructions (If wiring funds please fax a copy of this form to (315) 735-0415 Attn. Trust Department

Remit to Community Bank, NA

ABA # 0213-0538-6

Short Title Community Bk Syr

Address Dewitt, NY 13214

Special Instructions Attn: Trust Utica Omnibus FBO Plan Name

Account # 0012 136 156

Account Name Clients of Benefit Plans Administrator

Reminder: The rollover/transfer check should be made payable to the name of the receiving plan FBO participant name For example XYZ Corp Retirement Plan FBO John Doe