IMPORTANT BENEFITS NOTICE
FOR NEW HIRES

Employees with a continuous, regular appointment of at least six months who work at least 30 hours per week (.75 FTE) are eligible for insurance benefits and must enroll within 30 days of hire. In addition, employees with a continuous, regular appointment of at least six months who work at least 20 hours or more per week (.50 FTE to 1.00 FTE) must make an irrevocable decision about retirement within the first 30 days of hire. All employees, including student and temporary employees, are eligible to participate in the voluntary retirement programs. You can learn more about participation in the 457(b) Deferred Compensation Plan, 403(b) Supplemental Tax-Deferred Annuity, and the Roth 403(b) program, by contacting your Human Resources office.

What should I do to enroll? Your hiring official should schedule a benefits enrollment session with OSU Human Resources, (405) 744-5449, on the Stillwater campus, within the first week of hire. You will want to verify the time and location of your enrollment meeting with your supervisor. The enrollment session lasts approximately three hours. During this session, Benefits staff presents highlights of the benefit programs and assists employees with completion of enrollment forms. You are encouraged to view your benefit options at http://hr.okstate.edu/benefits/newemp prior to the enrollment session so that you will be better prepared to make informed choices. Insurance plan decisions are made and forms are usually turned in during the enrollment session.

May my spouse attend the enrollment session? Spouses are welcome. However, space is limited, so a reservation for the spouse should be made when the appointment is scheduled. Your spouse can also view benefit information online at http://hr.okstate.edu/benefits/newemp.

What happens if I fail to enroll in the insurance plans within the first 30 days of hire? You lose the opportunity to enroll in the health care plan of your choice until the next Annual Benefits Enrollment Period. You also lose the opportunity to participate in the optional dental and vision plans until the next Annual Benefits Enrollment Period. In addition, you will not be able to cover family members in the health care plan until the next Annual Benefits Enrollment Period. Late enrollment in other benefit programs can also have serious consequences, such as proof of insurability requirements (life and long-term disability).

What happens if I fail to make my retirement election within the first 30 days of hire? State law requires OSU enroll employees working .50 FTE or greater into the Oklahoma Teachers’ Retirement System if an election is not made within 30 days of the benefits eligibility date. Employees working .50 to .74 FTE are required to pay the contribution. OSU pays the contribution on employees working .75 FTE or greater. You will never be allowed to participate in the Alternate Retirement Plan (TIAA) if you fail to make a timely election.

When will my coverage become effective? All insurance benefits become effective the first of the month following your hire date even if the first day of a month is your hire date. Remember, you must enroll within 30 days of hire.

What do I need to bring to the enrollment session? Names, dates of birth, social security numbers, and supporting documentation (i.e. birth certificate, federal tax return, marriage license, divorce decree, custody agreements, adoption, or guardianships) of family members to be insured and persons named as beneficiaries.
How do I find out about withholdings from my pay and other personal information? You may view any of your personal information, benefit enrollments, and payroll information on Self Service Banner, https://my.okstate.edu. As soon as you are given access to OSU systems, you can access Self Service Banner. In order to protect your privacy, OSU assigns all new employees a campus-wide identification number (CWID) that will be used in place of your social security number in all university systems. You can access your CWID in your personal information on Self Service.

How do I obtain an OSU Employee Identification Card? Within 24 hours after Payroll Services receives an Electronic Personnel Action form (from your department), your information will be input into the Human Resources System. After your information is in the system, ID Card Services, 421 CLB, can produce your OSU ID.

How can I save for retirement? OSU offers three voluntary retirement programs that give all employees, including student and temporary employees, the opportunity to set aside money toward retirement. You decide how much money to contribute within the guidelines for each program. These contributions will be deducted from your paycheck and remitted to TIAA. Information about the 457(b) Deferred Compensation Plan, 403(b) Supplemental Tax-Deferred Annuity, and the Roth 403(b), can be found at http://hr.okstate.edu/benefits/vrp.htm.

Reminder of Deadlines

You have 30 days from date of hire to enroll in the insurance programs, and to make an irrevocable election for your retirement plan.

OSU Human Resources developed this information for the convenience of OSU employees. It is a brief interpretation of more detailed and complex materials. If further clarification is needed, the actual law, policy and contract should be consulted as the authoritative source. OSU continually monitors benefits, policy and procedures and reserves the right to change, modify, amend, or terminate benefit programs at any time.
2018 OSU HEALTHCARE AND FLEX ENROLLMENT/CHANGE FORM

EMPLOYEE INFORMATION – Please Print

Campus Wide ID: ______________________ Social Security #: ______________ - ___________ - ___________ Gender: M F
Employee Name: ________________________ □ Married □ Single □ Divorced □ Widowed □ Common Law
Home Telephone:________________________ Campus Telephone:____________________________________
Mailing Address:________________________
City:________________________ State:__________ Zip:__________ Email:______________________________
Birth Date: __ ___ / __ ___ / __________ Date of Hire __ ___ / __ ___ / ___ Effective Date ___ / 01 / 20___

HEALTH PLAN - BLUECROSS BLUESHIELD □ADD □DROP □WAIVE
□ BlueOptions □ BlueEdge High Deductible

DENTAL PLAN – CIGNA DENTAL PPO □ADD □DROP □WAIVE
□ Low Plan □ High Plan

VISION PLAN - EYEMED □ADD □DROP □WAIVE
□ EyeMed

FLEXIBLE BENEFITS

The maximum employee contribution for a health flexible spending account is $2,600 for 2017 and $2,650 for 2018. Maximum Dependent Care Account contributions are $5,000 per household. Health, dental and vision premiums paid by the employee are tax-sheltered.

Employee Contribution to Dependent Care (DCA) $ __________ Amount per month ________ # of months ________ $ ________ Goal thru 12/31
Employee Contribution to Flexible Spending Account (FSA) $ __________ Amount per month ________ # of months ________ $ ________ Goal thru 12/31
DEPENDENT INFORMATION Supporting documentation must be provided: birth certificates, federal tax return, marriage license, divorce decree, or legal documents, i.e., custody agreements, adoption, guardianships.

SPOUSE: Name: ____________________________ SSN: ____________________ ADD DROP
Date of Birth: ____________________________ Date of Marriage: ____________________________
Address □ (Check if same as employee): ____________________________
Gender: M F

CHILD: Name: ____________________________ SSN: ____________________ ADD DROP
Date of Birth: ____________________________
Address □ (Check if same as employee): ____________________________
Gender: M F

CHILD: Name: ____________________________ SSN: ____________________ ADD DROP
Date of Birth: ____________________________
Address □ (Check if same as employee): ____________________________
Gender: M F

CHILD: Name: ____________________________ SSN: ____________________ ADD DROP
Date of Birth: ____________________________
Address □ (Check if same as employee): ____________________________
Gender: M F

CHILD: Name: ____________________________ SSN: ____________________ ADD DROP
Date of Birth: ____________________________
Address □ (Check if same as employee): ____________________________
Gender: M F

CERTIFICATION SIGNATURES

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

☐ I authorize my employer to deduct from my pay the premium, if any, for the elected coverage. I understand that in the event in which I do not receive pay, premiums will be billed to my bursar account and are subject to cancellation for non-pay.

☐ To the best of my knowledge and belief, the information I have provided on this form is correct.

☐ I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

☐ I understand that coverage begins the first of the month following my eligibility.

☐ I understand my coverage begins the first of the month following the completion and return of this form if a change is requested mid-year.

EMPLOYEE SIGNATURE: ____________________________ DATE: ____________________________

If this is a mid-year change request please complete the Section 125 form to identify the qualifying event.
PLAN GUIDELINES FOR ELECTION CHANGES
Detach and retain for your records

IMPORTANT – YOU MUST READ THE FOLLOWING PLAN GUIDELINES BEFORE CompleTING THE FORM
Signatures on your form certify you have read this page and all your elections meet the Plan Guidelines.
Refer to Title 74 Oklahoma Statutes §1323, Fraud – Penalties

BlueCross BlueShield
You may decline BlueCross BlueShield health coverage if you have other verifiable group health coverage. You will be asked to provide proof of your coverage on the Waive OSU Employee Health Insurance form. If you lose other verifiable group health coverage, you are required to notify Employee Services within 30 days of the change.
To be eligible for health coverage, a child must be under the age of 26. It is your responsibility to notify your Insurance Coordinator when your child is no longer eligible for coverage. Neither BlueCross BlueShield nor the State Insurance Board (dental/vision) will pay claims on ineligible dependents even if you have paid premiums for that dependent. Additional details are available in the BCBS and EGID plan booklets.
Common-law spouses may only be added upon initial employment or during Annual Benefits Enrollment. Once publicly declared, a common law relationship can only be dissolved by legal divorce.

Health Savings Accounts
Employees must be enrolled in the BlueEdge High Deductible plan to participate in an HSA. Employees enrolled in “employee-only coverage” will receive $83.34 per month in employer contribution to their HSA account. Employer contributions must be included in the annual individual maximum. Employees with dependent coverage will receive $125 per month employer contribution to their HSA. HSA annual maximums are $3,450 for individual or $6,900 for family in 2018. $1,000 catch up allowed for those age 55 and over.

You are not eligible to participate in an HSA if:
- you are covered by Medicare (Part A and/or Part B); or
- you are claimed as a dependent on a tax return, or
- you are covered by another health plan that is not a high deductible plan

Changing or adding coverage for yourself and your dependents:
Mid-Year Changes: To be eligible to add, drop, or change coverage on yourself and/or your dependents subsequent to your initial employment (other than the Annual Benefit Enrollment period), you must have experienced a Qualifying Event. You must make your elections, sign the form, attach supporting documentation, and submit forms within 30 days of the Qualifying Event.
Strict consistency rules apply to all Qualifying Events. A benefit election change is only consistent with a Qualifying Event if the election changes are necessary or appropriate as a result of the event, i.e. adding Health coverage (benefit election change) is not consistent with the loss of a dependent child (Qualifying Event.)

Allowable Mid-Year Changes Within Plan Guidelines Include:
- Change in your legal marital status (common-law changes can only be made during annual enrollment or with legal divorce);
- Change in your number of dependents;
- Change in your, or your dependents employment status that directly effects eligibility;
- An event that causes your dependent to satisfy, or cease to satisfy eligibility requirements (over age limit, etc.);
- Changes in your, or your dependents, place of residence that directly effects DMO availability;
- Leaving on or returning from FMLA Leave, Leave Without Pay, USERRA Leave, Disability Leave.

Changes that do not fall into the above categories are generally not allowed except during the Annual Benefits Enrollment period.
If in doubt as to whether you qualify for a change, please contact your Insurance Coordinator. Your dependents are not eligible for any coverage in which you are not enrolled.
Health Savings Account (HSA) Acknowledgement

How to open your account

1. Access online registration at, www.mybenefitwallet.com

2. Choose "First Time User" and complete the requested information.

3. Look for a welcome letter in the mail at your home address. Do not throw this envelope away. Complete the Master Signature Card, designate account beneficiaries, and request a checkbook. Return the card to BenefitWallet.

4. Within four to seven business days of account activation, BenefitWallet will mail you a debit card. Debit cards and checkbooks are mailed in generic envelopes.

Important Information

- An HSA is a pre-tax savings account designated for qualified medical expenses. An HSA allows you to pay qualified medical expenses now, as well as save for future qualified medical expenses.
- The account has a $2.25 monthly fee for balances under $3,000.
- You have the opportunity to invest your HSA balance once it reaches $1,000 for a $2.90 monthly fee.
- The entire fee schedule is listed at http://hr.okstate.edu/sites/default/files/docfiles/BenefitWallet%20Fees.pdf.
- Unused funds roll over from year to year. There is no "use it or lose" rule. The money in your HSA is yours, regardless if you retire or separate from the University.
- 2017 HSA maximum contributions for an employee-only account per year is $3,450 or $6,900 for family coverage (must include any employer contributions). Employees age 55 or older may elect an additional $1,000 catch-up contribution.
- Per IRS regulations, you cannot have an HSA and FSA within the same calendar year.
- If you are enrolled in Medicare Part A and/or Part B, you cannot participate in an HSA.
- Refer to FAQs at www.mybenefitwallet.com.

Please check the applicable box(es):

[ ] BlueEdge, Employee only coverage, OSU Contribution: $83.34 per month;
Employees with Dependent Coverage, OSU Contribution $125.00 per month

[ ] BlueEdge, Employee Contribution: ___________________________ per month

[ ] STOP OSU and/or Employee Contribution Effective: ___________________________
(circle one (or both) if stopping for reasons relating to HSA governing rules, i.e., enrolled in Medicare)

In order to receive employer contributions or make employee contributions, I understand that I must open my Health Savings Account with BenefitWallet. Contributions will begin effective the month following the opening of my account, and/or the receipt of this form. If enrolled in Medicare Part A and/or B, I cannot participate in HSA. I understand that if I enroll in Medicare Part A and/or Part B, it is my responsibility to notify my employer to cease all further employee and/or employer contributions.

Employee signature ___________________________ Date ________________

Employee name ___________________________ CWID ________________

For office use only:
Account Opened: ___________________________ Effective Date: ________________

T:\Benefits\Forms\2018\2018 HSA Form_FINAL.docx Revised Fall 2017
TOBACCO AFFIDAVIT FOR OSU EMPLOYEES

Please Complete (Print):

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As part of OSU's Tobacco-free Workplace Initiative and to encourage the wellness of our employees, a tobacco-free incentive will be made available to employees which will reduce the cost of health coverage contributions of the employee.

A tobacco user is defined as a person who has smoked or used any tobacco products, such as cigarettes, cigars, smokeless tobacco products, e-cigarettes and/or vapors in the last 90 days*.

If you have used tobacco products within the last 90 days* you may still check the "No" box below, but ONLY if you meet the definition of tobacco user and have a medical condition which made it inadvisable to quit using tobacco products 90 days* before the effective date of coverage.

PLEASE PLACE AN "X" IN THE BOX THAT DESCRIBES YOUR TOBACCO USAGE.

Yes, Tobacco User

☐ By electing this option, you are affirming that you are a tobacco user.

No, Non-Tobacco User

☐ By electing this option, you are affirming that you do not use tobacco products.

Have completed a tobacco cessation program

☐ By electing this option, you are affirming that you have completed a tobacco cessation program. Please provide date of completion:

Employee's Signature: __________________________ Date: __________________________

I certify that the above information is true and correct. Falsification of University documents may result in corrective action, up to and including termination of employment; and/or demand of appropriate unpaid past premiums.
EMPLOYEE INFORMATION – Please Print

Campus Wide ID: __________________________ Social Security #: __________ - __________ - ________ Gender: M F

Employee Name: ___________________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Common Law

Home Telephone: ___________________________ Campus Telephone: ___________________________

Mailing Address: ___________________________

City: __________________ State: ______ Zip: __________ Email: ________________________________

Birth Date: __ / __ / ____ Date of Hire: __ / __ / ____ Effective Date: __ / __ / 01 / 20 ___

Basic Employee Life/AD&D
Employee Only—Basic Life Insurance and Accidental Death and Dismemberment is OSU/A&M System-provided (two times annualized salary not to exceed $200,000)

Supplemental Employee Life Insurance ☐ ADD ☐ DROP ☐ WAIVE
☐ I am currently enrolling in or have supplemental guaranteed issued (GI) life coverage of: _____, _____, _____ ($10,000 Increments)

☐ I am applying for supplemental life by EOI of: _____, _____, _____ ($10,000 Increments)

The maximum GI limit for Employee Supplemental Life Insurance is two times the annualized salary or $300,000, whichever is less. When you are first eligible for supplemental life coverage, you can elect this maximum GI without evidence of insurability. At each annual enrollment, you can elect to increase supplemental life coverage by 4 increments of $10,000 (total coverage not to exceed the maximum GI limit) without EOI. Total supplemental life coverage, up to five times the annualized salary not to exceed $750,000, is available if you complete an Evidence of Insurability form online. Liberty Mutual processes the form and additional coverage is effective after approved.

Maximum: $______, _______ (for OSU Benefits Use only)

Supplemental Spouse Life Insurance ☐ ADD ☐ DROP ☐ WAIVE
☐ I am currently enrolling in or have supplemental life GI coverage of: _____, _____, _____ ($10,000 Increments)

☐ I am applying for additional supplemental life by EOI of: _____, _____, _____ ($10,000 Increments)

A spouse cannot be added for Supplemental Life Insurance if the spouse is also a benefit-eligible employee of OSU. The maximum GI limit for Spouse Supplemental Life Insurance is one times the annualized salary or $130,000, whichever is less. When initially eligible for spouse coverage, you can elect coverage in $10,000 increments without an EOI up to one times your annual earnings not to exceed $130,000. At each annual enrollment, you can elect to increase spouse supplemental life coverage by $10,000 not to exceed the maximum GI limit. At all other times, an Evidence of Insurability form must be completed online. Liberty Mutual processes the form and coverage is effective after approved. Spouse coverage cannot exceed the maximum limit of $380,000.

SPouse: Name: _____________________________ SSN: _________ - _________ - _________

Date of Birth: __ / __ / ____ Gender: M F

Maximum: $______, _______ (for OSU Benefits Use only)

Supplemental Dependent Child(ren) Life Insurance
When initially eligible for Dependent Child(ren) Supplemental Life Insurance, you can elect coverage. From birth to 14 days, the benefit amount is $100. From 14 days to 6 months, the benefit amount is $1,000. Children can be covered from birth to age 26. If a full-time student, dependent children may continue to be covered.

☐ ADD ☐ DROP ☐ WAIVE

Elected Amount:
☐ $ 2,500 for each eligible dependent child
☐ $ 5,000 for each eligible dependent child
☐ $ 7,500 for each eligible dependent child
☐ $10,000 for each eligible dependent child
### Beneficiary Information for Employee Life Coverage

Please list your beneficiary information below. Beneficiary for Basic Employee and Employee Supplemental Life can be different. Life proceeds will be split equally among beneficiaries listed, unless otherwise designated. **Note:** The employee is the beneficiary for spouse or children insurance coverage, if applicable.

| Primary Beneficiary  | Address (Street, City, State & Zip) | Relationship | Benefit % (MUST total 100%)*
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| Contingent Beneficiary | Address (Street, City, State & Zip) | Relationship | Benefit % (MUST total 100%)*
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### 2018 Long-Term Disability (LTD)

Long-Term Disability coverage is employee-paid. Proof of Insurability is required if enrolling after 30 days from initial benefits eligibility.

LTD Election:

- [ ] 60%
- [ ] Waive/Cancel

### READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my pay the premium, if any, for the elected coverage. I understand that in the event in which I do not receive pay, premiums will be billed to my bursar account and are subject to cancellation for non-pay.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- I understand that coverage will begin the first of the month following my eligibility.
- I understand my coverage begins the first of the month following the completion and return of this form if a change is requested mid-year.
- If evidence of insurability is required, coverage will begin the first of the month following approval by the appropriate Insurance Underwriter.

**EMPLOYEE SIGNATURE:** ___________________________ **DATE:** ___________________________
Irrevocable Election Agreement to Participate
In The Oklahoma Teachers' Retirement System or
The Alternate Retirement Plan for Oklahoma State University

THIS Agreement is entered into this ___ day of ____________, 20___, between Oklahoma State University (the “University”) and you, __________________________ (the “Eligible Employee”), to enable you to make a one-time irrevocable election with respect to participation in the Oklahoma State University Alternate Retirement Plan (the “Alternate Plan”) or the Oklahoma Teachers’ Retirement System (“OTRS”) as discussed below.

1. Eligible Employee. The University has determined that you are an Eligible Employee as defined in the Alternate Retirement Plan Act for Comprehensive Universities (the “Act”). As an Eligible Employee, you are required to make a one-time irrevocable election within 30 days of your initial date of eligibility with the University to elect to be a participant in the Alternate Plan or a participant in OTRS. Your election, once made, may never be revoked and will be binding on you and the University.

2. Information Provided. Along with this Agreement, the University is providing to you information which will enable you to make an informed decision as to whether you should elect to be a participant in the Alternate Plan or OTRS, and you have the opportunity to request additional information. You may wish to consult with your financial advisor, attorney, or accountant as to the implications of electing to participate in the Alternate Plan or OTRS.

3. Alternate Plan. The Alternate Plan is a defined contribution plan and is intended to meet the qualification requirements of Section 401(a) of the Internal Revenue Code of 1986. The University will make contributions each year to your account in the Alternate Plan while you are an Eligible Employee. You will have the ability to direct the investment of your account among the Alternate Plan’s selected investment options. The benefits to be provided through the Alternate Plan are not the obligations of the State of Oklahoma but are the obligation of the University. The only benefit to be provided under the Alternate Plan is the vested portion of contributions (and investment earnings thereon) made to the Alternate Plan by the University. All contributions by the University are fully vested after two consecutive years of service with the University.

4. No Warranties or Representations. The University has provided you with information to allow you to make an informed decision; however, the University may not advise you as to whether participation in either the Alternate Plan or OTRS is best for you. You should make your decision as to whether participation in the Alternate Plan or OTRS is best for you based upon various factors including, but not limited to, your age, years of service, compensation, and requirements of post-retirement income. As is the case with all University benefit plans and programs, the University reserves the right to amend, modify, or terminate the Alternate Plan including reducing the amount of the University’s contribution to the Alternate Plan. The University has the sole discretion to make all eligibility and benefit determinations with respect to the Alternate Plan. Likewise, the State of Oklahoma has the sole discretion to make all eligibility and benefit determinations with respect to OTRS. The University will contribute the current member contribution fee to OTRS for employees who elect to participate in OTRS. However, any future changes to the current member contribution schedule are not an automatic obligation of the University.
5. **Election to Participate.** Having had the opportunity to be fully informed with regard to the ramifications of electing to participate in either the Alternate Plan or OTRS, you must make the one-time irrevocable election. Regardless of changes in either Plan in the future, you will not be able to change this election.

- **Alternate Plan:** By checking this box, you elect to participate in the Alternate Plan. With this election you will not be eligible to participate in OTRS and will be subject to a two year vesting period. This vesting period requires that you meet employment requirements of two years of continuous regular service (or academic equivalent).

- **OTRS:** By checking this box, you elect to participate in OTRS and understand that you will not be eligible to participate in the Alternate Plan.

**Failure to Make an Election.** If you fail to make an election in this Agreement within 30 days of your date of hire or initial eligibility, you will be enrolled to participate in OTRS and will not be eligible to participate in the Alternate Plan.

6. **Binding Effect.** Your election is irrevocable and binding upon you and the University. You also agree, depending upon which plan you elect, to be bound by the terms and provisions of the Alternate Plan or OTRS, as applicable.

Dated the day and year first above written.

__________________________________________  ________________________________
(Signature of Eligible Employee)  (Signature of Notary)

Printed Name: ____________________________  Employee ID: ____________________________

Telephone: ________________________________  My commission expires: _______________

Date of Birth: ______________________________

Date of Election Deadline Date: ________________ (SEAL)

30-Day Election Deadline Date: ________________

Return original form to OSU Human Resources, 106 Whitehurst, Stillwater, OK 74078

FOR OFFICE USE ONLY: □ BI-WEEKLY  □ MONTHLY  EFFECTIVE DATE: ________________

<table>
<thead>
<tr>
<th>ELIGIBLE FOR OSU CONTRIBUTIONS</th>
<th>NOT ELIGIBLE FOR OSU CONTRIBUTIONS</th>
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<tr>
<td>□ ARP without Funding Surcharge (Previously optional OTRS—Job Codes A-C-E-G, H, if 45 or over 45; Job Codes I-J-P-Q-R, regardless of age) TIR</td>
<td>□ ARP without Funding Surcharge (Previously optional OTRS—Job Codes A-C-E-G, H, if 45 or over 45; Job Codes I-J-P-Q-R, regardless of age) TIR — Exempt</td>
</tr>
<tr>
<td>□ ARP with 2.5% Funding Surcharge (Previously mandated OTRS—Job Codes A-C-E-G, H, if under 45) TIR, TRA</td>
<td>□ ARP with 2.5% Funding Surcharge (Previously mandated OTRS—Job Codes A-C-E-G, H if under 45; Job Code B: Visiting Fac in-state, Adjunct if in OTRS) TIR — Exempt, TRA</td>
</tr>
<tr>
<td>□ OTRS Paid by OSU (Job Codes A-C-E-G-I-J-P-Q-R, regardless of age) TRA, TRR</td>
<td>□ OTRS Paid by Employee (Job Codes A-B-C-E-G-I-J-P-Q-R, regardless of age) TRA, TRR</td>
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Working Title: ____________________________

NOTES:  ____________________________________________

NOTES:  ____________________________________________

OTRS Personal Data Form attached: ______ yes ______ no
PERSONAL DATA
Page 1 of 2

All data contained on the Personal Data form must match the data submitted electronically by the employer via monthly contribution reports.

Please designate the reason for completing this form: □ New Member  □ Post Retirement Employment  □ Position Change
□ Dist. Transfer  □ Beneficiary Information  □ Address Change  □ Other

1. Social Security Number

Name of School District or Institution

County

2. Legal Name (All requests for change of name must include legal documentation [i.e. Marriage Certificate, Divorce Decree, etc.])

(Last) (First Given Name) (Middle Given Name) (Maiden Name)

3. Permanent Mailing Address (Address must match address on monthly contribution reports)

(City) (State) (Zip Code)

4. Date of Birth

(Month) (Day) (Year)

Place of Birth (Town) (County) (State or Country)

5. Date of Employment ________________ Position you will hold

Hours typically worked per week ______

Position’s total number of days worked per Fiscal* year ______

* i.e. 260 days/year for most 12-month employees from July 1 – June 30.

6. a. Have you ever been a member of the Oklahoma Teachers Retirement System?

□ Yes  □ No

b. Were you a member before starting this job?

□ Yes  □ No

c. Have you withdrawn an account?

□ Yes  □ No

(Optional)

7. If the answer to questions No. 6.c. is “yes,” please complete the applicable columns listing most recent employment first.

(School District, College or Agency) (County) (Year) (Under What Name) (Approximate Withdrawal Date)

I hereby declare and affirm, under penalty of perjury, that to the best of my knowledge and belief, all statements and answers as written or printed herein are full, complete, and true whether or not written by my own hand.

Signature of Member __________________________ Date __________________________

I certify the above-named employee meets the requirements for membership in the Oklahoma Teachers Retirement System.

Superintendent / Payroll Officer __________________________

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PERSONAL DATA Page 2 of 2
Oklahoma Teachers Retirement System Designation of Beneficiaries

Name ___________________________________________________________________________ SSN or OTRS Client ID __________

All information (full name, date of birth, age, relationship and address of proposed beneficiary/beneficiaries) must be completed.

SECTION 1 – PRIMARY BENEFICIARY(IES): The sole beneficiary if living at the member’s death. If more than one beneficiary is named in this section, the interest of all beneficiaries shall be equal. Upon the death of any designated primary beneficiary, his/her interest shall pass to the surviving primary beneficiaries in equal share. If you have more than two primary beneficiaries, use a copy of this page.

1. I hereby designate

   First Name ___________________________   Middle Name ___________________________   Last Name ___________________________

   Relationship ___________________________   Address _______________________________________

   Date of Birth ___________   Age ___________

2. I hereby designate

   First Name ___________________________   Middle Name ___________________________   Last Name ___________________________

   Relationship ___________________________   Address _______________________________________

   Date of Birth ___________   Age ___________

as my primary beneficiary(ies) if living, or in the event of prior death of all primary beneficiaries, then payment is to be made to the contingent beneficiaries in Section 2.

SECTION 2 – CONTINGENT BENEFICIARY(IES): Does not share in the amount due if any of the primary beneficiaries are living at the member’s death. Payment will be made to the continent beneficiaries if all primary beneficiaries are deceased. If more than one contingent beneficiary is named, payment will be made in equal shares. Upon the death of a contingent beneficiary, his/her interest shall pass to the surviving contingent beneficiaries in equal shares. If you have more than two contingent beneficiaries, use a copy of this page.

1. I hereby designate

   First Name ___________________________   Middle Name ___________________________   Last Name ___________________________

   Relationship ___________________________   Address _______________________________________

   Date of Birth ___________   Age ___________

2. I hereby designate

   First Name ___________________________   Middle Name ___________________________   Last Name ___________________________

   Relationship ___________________________   Address _______________________________________

   Date of Birth ___________   Age ___________

3. I hereby designate

   First Name ___________________________   Middle Name ___________________________   Last Name ___________________________

   Relationship ___________________________   Address _______________________________________

   Date of Birth ___________   Age ___________

as my contingent beneficiary(ies) to receive the amount set forth in the Teachers Retirement Law in the event of my death. (Contingent beneficiaries do not share in the amount due if any of the primary beneficiaries are living at my death.)

Minor Beneficiary: Under Oklahoma law, if a minor child (younger than 18 years of age) is designated as beneficiary, it will be necessary that a guardian be appointed by the court before payment is made.

Revolving Previous Designation of Beneficiary: By this election, I hereby revoke all other former designations made by me and expressly reserve the right to make other and further changes at any time I may elect. If there is no designated beneficiary living at the time of my death, any amount due me shall be paid as provided by the Teachers Retirement Law.

_________________________               ___________________________
Signature                                      Date

(The signature must appear exactly as the name appears on the top of this form. Power of Attorney or Guardian signature is not valid unless accompanied by court order specifically authorizing the right to change beneficiaries.)
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- Your beneficiary’s Social Security Number, birth date and address, if possible
- Your selected investment allocations. Need information about your investment options? Please go to TIAA.org/okstate to view the menu.

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   - If you are a first-time user: Click Register with TIAA to create your user ID and password.
   - If you are a returning user: Enter your TIAA user ID and click Log In.
3. Follow the prompts and print out the confirmation page. You are now enrolled.

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- **Convenience**
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  No taxes are taken on your contributions or their earnings, until you take money out of the plan.²

- **Diverse investments**
  You can build a portfolio of professionally managed investments suited to your personal goals and risk tolerance.

- **Pretax savings**
  If applicable to your plan, every dollar you save is on a pretax basis, which can reduce your current taxable income.

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1. Social Security Administration, http://ss.a.gov/pubs/10035.html#a0=1
2. Does not apply to Roth contributions. All withdrawals are subject to ordinary income tax. Withdrawals prior to age 59½ may be subject to an additional 10% penalty.

Distributions from 403(b) plans before age 59½, severance from employment, death, or disability may be prohibited, limited, and/or subject to substantial tax penalties. Different restrictions may apply to other types of plans.

Investment, insurance and annuity products are not FDIC insured, are not bank guaranteed, are not insured by any federal government agency, are not a condition to any banking service or activity, and may lose value.

Investment products may be subject to market and other risk factors. See the applicable product literature, or visit TIAA.org for details.

You should consider the investment objectives, risks, charges and expenses carefully before investing. Please call 877-518-9161 or log on to TIAA.org for current product and fund prospectuses that contain this and other information. Please read the prospectuses carefully before investing.

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OSU/A&M RETIREMENT PROGRAM VOLUNTARY 403(b) AND 457(b) PLANS

SALARY REDUCTION AGREEMENT

| Employee Name: Last, First M1 (PLEASE PRINT) | Date of Birth |
| CWID #: | Reason for completing form: |
| Home Phone #: | □ New Participant |
| | □ Changing Contribution |
| Campus Phone #: |

As an employee of OSU/A&M (Connors State College, Langston University, Northeastern Oklahoma A&M College, Oklahoma Panhandle State University or Oklahoma State University), you may contribute a portion of your compensation to the OSU/A&M Voluntary Section 403(b) and/or 457(b) Contribution Plan(s). The amount that you choose to defer shall not exceed the applicable limitations of Internal Revenue Code Sections 415, 402(g) and 414(v), whichever is less, as applicable. Amounts contributed will be invested with TIAA. You select among the available investment options.

The minimum contribution is $15.00 per month. The maximum contribution limit for calendar year 2018 is $18,500 for each plan. However, if you are at least age 50 (on December 31 of the year of your election), a $6,000 "catch up" allowance provides that you may contribute up to $24,500 for calendar year 2018 for each plan. The 403(b) and 457(b) maximum limits are subject to you having enough eligible annual compensation to contribute at the limit. If you contribute to a non-OSU/A&M 403(b) and/or 457(b) plan or another qualified retirement plan during the same calendar year, you should consult your tax advisor regarding the overall limits that apply in your individual circumstances.

This Agreement may become effective on the following: (i) the first day of the month following receipt of this executed form by your local Human Resources office or (ii) the first day of a future month specified by you. This Agreement supercedes and replaces any previously submitted Agreement for this plan, and shall remain in effect unless revoked or modified in writing.

## COMPENSATION DEFERRAL ELECTIONS

| 403(b) Plan (Pre-tax contributions) | Roth 403(b) Plan (Post-tax contributions) |
| $ | Amount per month |
| $ | Annual Goal amount |
| □ Stop 403(b) (pre-tax) deduction |
| $ | Amount per month |
| $ | Annual Goal amount |
| □ Stop 403(b) (post-tax) deduction |

| 457(b) Plan (Pre-tax contributions) | Total Pre-Tax 403(b) plus Roth 403(b) Amounts, if applicable |
| $ | Amount per month |
| $ | Annual Goal amount |
| □ Stop 457(b) (pre-tax) deduction |
| $ | Total Monthly Amount |
| $ | Total Annual Goal Amount |

Note: Combined 403(b) and Roth 403(b) contributions cannot exceed annual maximum limit for 403(b) plan contributions. If deductions reach the maximum amount within the calendar year, OSU/A&M will stop payroll deductions until January 1 of the following calendar year. Your election will remain in force until you change it, no longer meet eligibility requirements, or no longer meet minimum pay requirements.

After a review of the materials provided by TIAA and OSU/A&M, I elect to participate in the 403(b) and/or the 457(b) plan. I understand that this Salary Reduction Agreement does not establish an account with TIAA and that I must set up an account via www.tiaa.org/okstate.

Effective Date: date for requested change to take effect*: __________ / 01 / 20 __________

*The effective date must be the first day of the following month this form is received by your local Human Resources office, or the first day of a subsequent month.

Employee Signature: ___________________________ Date: ___________________________
ACKNOWLEDGMENT OF RECEIPT OF ELECTION AGREEMENT FOR OKLAHOMA STATE UNIVERSITY RETIREMENT FOR AN ELIGIBLE EMPLOYEE

I, ___________________________ (the “Eligible Employee”), an employee of Oklahoma State University (the “University”) hereby acknowledge receipt of information related to my election to participate in either the Oklahoma State University Alternate Retirement Plan (the “Alternate Plan”) or the Oklahoma Teachers’ Retirement System (“OTRS”). I understand that I must make an affirmative election within 30 days of my date of eligibility with the University. I also understand that if I do not make an affirmative election to participate in the Alternate Plan, I will automatically participate in OTRS. I understand that my election, once made, may never be revoked and will be binding on the University and me.

I acknowledge that I have been given an Irrevocable Election Agreement for Oklahoma State University Retirement for an Eligible Employee. The University has presented to me information regarding the two retirement plans. This will enable me to make an informed decision as to whether I should elect to be a participant in the Alternate Plan or OTRS. I also have the opportunity to further review the following information:

- CD Presentation of OTRS and OSU Alternate Retirement Plans (also available on the web site at www.okstate.edu/osu_per/benefits/retinfo.html)
- ARP – TIAA Information Sheet
- OTRS Plan Summary

I have been advised that I may wish to consult with my financial advisor, attorney, or accountant as to the implications of electing to participate in the Alternate Plan or OTRS.

Executed this __________ day of ______________, 20____ by the Eligible Employee and by the University.

Employee Signature

Employee CWID #: ____________________

Telephone: _________________________

FOR OFFICE USE ONLY

By: _______________________________

Title: ____________________________

Employee Date of Eligibility: ______________

Election Due Date: ___________________