

Deferred Compensation Plan Participant Enrollment Form



(for Employers Not Electing NRECA's Administrative Services)

Employer: Use this form to enroll a new participant in your organization's deferred compensation program and, if desired, submit an initial salary deferral. Please print neatly in blue or black ink. To send subsequent salary deferrals, complete a Homestead Funds Group Purchase Form.

It is the employer's responsibility as plan administrator to verify plan and participant eligibility.

Return this completed form along with a check drawn on the employer's account for the amount of the salary deferral to:

REGULAR MAIL

Homestead Funds
c/o BFDS
P.O. Box 219486
Kansas City, MO 64121-9486

OVERNIGHT MAIL

Homestead Funds
c/o BFDS
330 W. 9th Street, 1st Floor
Kansas City, MO 64105-1514
Attn: Shareholder Services

Sending forms to NRECA will slow down processing.

If you need help completing this form, or if you have a question about Homestead Funds or a participant account, call Homestead Funds at **1-800-258-3030**.

Be sure to sign this completed form (section 4).

1. Plan Ownership

Tell us how your plan is registered.

NRECA Member/Employer Name

Employer's Tax Identification Number

Participant Exchange Options. Check One:

- This plan **does not** allow participants and authorized employer representatives to make fund exchanges by telephone.
- This plan **does** allow participants and authorized employer representatives to make fund exchanges by telephone.

2. Employer Address

Tell us to whose attention plan statements and tax forms should be mailed and provide your cooperative's street address. This may be a different person than the authorized employer representative in Section 4. **A P.O. Box will not be accepted as a street address. A rural route will be accepted.**

Benefit Administrator's First Name

Middle Initial

Last

Phone Number

Employer's Street Address/Rural Route

City

State

ZIP

If you want account correspondence sent to an address other than the cooperative's street address, give us your mailing address. Your mailing address may be a P.O. Box.

Mailing Address

City

State

ZIP

3. Participant Enrollment

Tell us the participant's name and identifying information.

Participant's First Name Middle Initial Last

Participant's Social Security Number Participant's Birth Date (mm/dd/yyyy)

Fund Selections: If sending a salary deferral (in the form of a check drawn on the employer's account) with this form, indicate how this amount should be allocated by fund. If not sending a salary deferral with this form, check the box next to each fund that will be opened.

- | | |
|---|--|
| <input type="checkbox"/> Daily Income (168) \$ _____ or _____ % | <input type="checkbox"/> Value (176).....\$ _____ or _____ % |
| <input type="checkbox"/> Short-Term Gov. (170)..... \$ _____ or _____ % | <input type="checkbox"/> Small-Company (178).....\$ _____ or _____ % |
| <input type="checkbox"/> Short-Term Bond (172) ... \$ _____ or _____ % | <input type="checkbox"/> International Value (180) \$ _____ or _____ % |
| <input type="checkbox"/> Stock Index (174) \$ _____ or _____ % | <input type="checkbox"/> Growth (182)\$ _____ or _____ % |
| Total\$ _____ or 100% | |
| (Total dollars must match check amount.) | |

Duplicate Mailing Address: If you want account statements sent to the participant as well as to the employer, provide the participant's address below.

Participant's Mailing Address

City

State

ZIP



Be sure to sign this form. We cannot act on your instructions without a signature.

4. Employer Signature

By signing this form, I certify that

- I have received, read and agree to the terms of the prospectus for the funds in which the employer is investing. The Homestead Funds prospectus is available at www.homesteadfunds.com or by calling **1-800-258-3030**. I have the authority and legal capacity to purchase mutual fund shares on behalf of my employer and am of legal age in my state and believe such investment is suitable for my organization.
- The employer has received, read and completed a deferred compensation program Plan Document, and a deferred compensation program Election Form, which set forth the terms and conditions of the employer’s participation in the deferred compensation program.
- I understand that it is the employer’s responsibility to determine that all requests are in compliance with the plan’s provisions.
- I understand that if Homestead Funds is directed to close this account after it has been established, any shares will be redeemed at the then current price and the proceeds will be returned to the employer. This may result in a gain or loss from the original investment.
- The employer understands that all shares will be purchased at the net asset value next determined after receipt by BFDS of deposits in good order, as described in the prospectus.
- The employer authorizes Homestead Funds, BFDS, their agents and affiliates to act on any instructions believed to be genuine for any service authorized by the employer on this form and agrees that they will not be liable for any resulting loss or expense to the employer resulting from such reliance.
- I understand that I cannot authorize my own enrollment.
- The tax identification number shown in section 1 of this form is correct.

▶ **X** _____
 Signature of Authorized Employer Representative Title Date

 Print Name