



ILLINOIS
DEPARTMENT OF CENTRAL
MANAGEMENT SERVICES
P.O. Box 19208, Springfield, IL 62794-9208

STATE EMPLOYEES' DEFERRED COMPENSATION PLAN ENROLLMENT FORM

Please type or print clearly in ink. Initial any corrections, additions, deletions or changes in pen. Complete all sections. For more information, call the Deferred Compensation Office at 1-800/442-1300, 1-217/782-7006 or TDD/TTY 1-800/526-0844.

Last Name	First	Middle Initial	Social Security Number	Date of Birth
Street		City/State		Zip Code
Agency or University			Office Phone Number () ()	Home Phone Number () ()
Work Address			Payroll Code No. _____ <small>(See your pay stub)</small>	

SECTION A: TRANSACTION TYPE - Check appropriate box.

- Initial Enrollment Re-enrollment of a Former Participant

SECTION B: AMOUNT OF DEFERRAL - The minimum amount of deferral is \$10 per pay period or \$20 per month, whichever is greater. Indicate the amount to be deducted from each paycheck. Deferrals can begin no sooner than the first pay period of the next month.

- I hereby elect to participate in the State Employees' Deferred Compensation Plan. I authorize the State of Illinois to defer from my total compensation \$ _____ each pay period until my termination, modification or revocation of this amount, effective the first or second pay period in _____ (month) (year).

SECTION C: INVESTMENT REQUEST - Select one or a combination in which to invest your deferrals. The percentages must total 100% and must be in whole numbers with no fractions.

I hereby request that my Deferred Compensation deferrals be invested in the following manner:

These funds are one-step options that make it easy for you to invest for retirement. Simply choose the fund with a target date closest to the year in which you plan to retire and your funds will be managed for you.

T. Rowe Price Retirement Funds:

- _____ % Retirement 2055 Fund/TRRNX
- _____ % Retirement 2050 Fund/TRRMX
- _____ % Retirement 2045 Fund/TRRKX
- _____ % Retirement 2040 Fund/TRRDY
- _____ % Retirement 2035 Fund/TRRJX
- _____ % Retirement 2030 Fund/TRRCX
- _____ % Retirement 2025 Fund/TRRHX
- _____ % Retirement 2020 Fund/TRRBX
- _____ % Retirement 2015 Fund/TRRGX
- _____ % Retirement 2010 Fund/TRRAX
- _____ % Retirement 2005 Fund/TRRFY
- _____ % Retirement Income Fund/TRRIX

These funds are the options if you want to select your own investment mix.

- _____ % Vanguard Prime Money Market Fund Inst. Shares/VMRXX (money market)
- _____ % Stable Return Fund (investment contracts)
- _____ % Vanguard Total Bond Market Index Fund Inst. Shares/VBTIX (bond index)
- _____ % T. Rowe Price New Income Fund/PRCIX (bonds)
- _____ % Fidelity Puritan Fund/FPURX (stocks & bonds)
- _____ % Vanguard Institutional Index Fund Inst. Plus Shares/VIIX (stock index)
- _____ % Legg-Mason Value Trust/LMVFX (large-company stocks)
- _____ % LSV Value Equity/LSVEX (large-company stocks)
- _____ % Wellington Trust Diversified Growth Portfolio (large-company stocks)
- _____ % Wells Fargo Large Company Growth Fund/NVLCX (large-company stocks)
- _____ % Columbia Acorn Fund/ACRNX (small-company stocks)
- _____ % Ariel Fund/ARGFX (stocks - social restrictions/advisor minority owned)
- _____ % Janus Adviser International Growth Fund/JIGFX (stock outside U.S.)
- _____ % T. Rowe Price International Stock Fund/PRITX (stocks outside U.S.)
- _____ % Northern Small Cap Value Fund/NOSGX (small-company stocks)

READ THIS INFORMATION COMPLETELY BEFORE SIGNING

I hereby acknowledge receipt of a copy of the Plan and agree to the terms and conditions. I hereby acknowledge that I have received and read a prospectus for each mutual fund in which I am investing. I understand and acknowledge that all amounts of compensation deferred pursuant to the Plan and all income attributable to such amounts shall be held in one or more custodial accounts for the exclusive purpose of participants and beneficiaries under the Plan. I understand that participation in the Deferred Compensation Plan is a benefit offered by the State of Illinois. In return for this benefit, I and my heirs, successors, and assignees shall hold harmless the State and its employees, officials, agents, assignees, and successors from any liability for all acts in good faith.

SIGNATURE X _____ DATE _____

Send completed form to your Agency Liaison - or send directly to the Department of Central Management Services.

Liaison Name _____ Agency _____ Date _____ Phone No. _____	Approval of Deferred Compensation Office required before any transaction takes place. Date _____ By _____
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In compliance with the State and Federal Constitution, the Illinois Human Rights Act, the Americans with Disabilities Act and Section 504 of the Federal Rehabilitation Act, the Department of Central Management Services does not discriminate in employment, contracts, or any other activity.



**STATE EMPLOYEES' DEFERRED COMPENSATION PLAN
BENEFICIARY ELECTION FORM**

Please type or print clearly in ink. Initial any corrections, additions, deletions, or changes in pen. For more information, call the Deferred Compensation Office at 1-800/442-1300, 1-217/782-7006 or TDD 1-800/526-0844.

Last Name	First	Middle Initial	Social Security Number	Pay Code
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BENEFICIARIES (A beneficiary may be a person, trust, estate, or other legal entity.) The percentages for both the Primary Beneficiaries and the Contingent Beneficiaries must be in whole numbers and each should total 100%.

- Designate "P" or "C" for Primary or Contingent Beneficiary. List all Primary Beneficiaries first.

<i>P or C</i>	Last Name	First	Middle Initial	Relationship	Date of Birth	Social Security No.
	Street			City/State/Zip		% Percent to Receive
<i>P or C</i>	Last Name	First	Middle Initial	Relationship	Date of Birth	Social Security No.
	Street			City/State/Zip		% Percent to Receive
<i>P or C</i>	Last Name	First	Middle Initial	Relationship	Date of Birth	Social Security No.
	Street			City/State/Zip		% Percent to Receive
<i>P or C</i>	Last Name	First	Middle Initial	Relationship	Date of Birth	Social Security No.
	Street			City/State/Zip		% Percent to Receive
<i>P or C</i>	Last Name	First	Middle Initial	Relationship	Date of Birth	Social Security No.
	Street			City/State/Zip		% Percent to Receive
<i>P or C</i>	Last Name	First	Middle Initial	Relationship	Date of Birth	Social Security No.
	Street			City/State/Zip		% Percent to Receive

READ THIS INFORMATION COMPLETELY BEFORE SIGNING

- Participants may designate primary and contingent beneficiaries. Contingent beneficiaries become effective only after the death of all primary beneficiaries prior to the death of the participant. Once a primary beneficiary becomes entitled to the benefits, the contingent designation by the participant is no longer in effect.
- If more than one beneficiary is named in either category, benefits will be paid according to the following rules:
 - Beneficiaries can be designated to share equally or to receive specific percentages.
 - If a beneficiary dies before the participant, the benefits will be paid only to the surviving beneficiaries. If more than two beneficiaries are originally named to receive different percentages of the benefits, surviving beneficiaries will share in the same proportion to each other as indicated in the original designation.
Example: Original designation is: John Doe, 10%; Mary Doe, 50%; and William Doe 40%. If Mary Doe dies before the participant, John Doe will be entitled to receive 20% of the benefits and William Doe, 80%.
- Beneficiary designations may be changed at any time by filing a new form with the department. The new designation will be effective when received by the department.
- If a beneficiary has not been designated, or all designated beneficiaries have died prior to the participant's death, or the designation is ineffective for any reason, the estate of the participant will be the beneficiary.

I hereby elect my beneficiary(ies) as named above. This designation of beneficiaries supersedes all prior designations of beneficiaries I have made.

Signature X _____ Date _____

Send all three copies of completed form to your Agency Liaison or directly to the Deferred Compensation Office

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