State of Hawaii
PTS Deferred Compensation Retirement Plan
For Part-Time, Temporary, and Seasonal/Casual Employees
(Participating Employers include: State of Hawaii and County of Kauai)

ENROLLMENT FORM

Employer: ☐ State of Hawaii ☐ County of Kauai

Pursuant to Section 88F-2 Hawaii Revised Statutes, you have been enrolled in the PTS Deferred Compensation Retirement Plan. Please type or print in ink. Complete ALL information. Failure to complete and return this form may delay or prevent receiving your distribution check after you separate from service.

SEND YOUR COMPLETED FORM TO:
PenServ Plan Services, Inc.
PO Box 3109
West Columbia, SC 29171

SECTION I - PARTICIPANT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
MAILING ADDRESS	CITY	STATE	ZIP CODE
EMAIL		BEST CONTACT NUMBER	

SECTION II - EMPLOYMENT INFORMATION

DEPARTMENT	DIVISION / SCHOOL
POSITION TITLE(S)	

1) Are you employed in any other job(s) with the Employer listed above? ☐ Yes ☐ No

   If YES, with what department(s)? _____

   a) Do these other job(s) provide you membership in the State Employees' Retirement System (ERS)? ☐ Yes ☐ No

2) Are you an ERS retiree collecting monthly retirement benefits or ERS member who is eligible to retire under ERS guidelines without early retirement penalties? ☐ Yes ☐ No

IMPORTANT: If you answer YES to Questions #1a or #2 above, be sure to notify your employer immediately to prevent problems with payroll deductions related to the PTS Deferred Compensation Retirement Plan.

SECTION III - BENEFICIARY INFORMATION

Primary Beneficiary Information *(Person to whom you wish to leave your money in case of your death.)*

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP		SOCIAL SECURITY NUMBER
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	PERCENT ALLOCATED %
NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP		SOCIAL SECURITY NUMBER
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	PERCENT ALLOCATED %

Total needs to equal 100% _____ %

Contingent Beneficiary Information *(Person to whom you wish to leave your money in case of your death if Primary dies.)*

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP		SOCIAL SECURITY NUMBER
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	PERCENT ALLOCATED %
NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP		SOCIAL SECURITY NUMBER
MAILING ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	PERCENT ALLOCATED %

Total needs to equal 100% _____ %

SECTION IV - SIGNATURE *(Certification Section)*

I certify that the above information is accurate. I understand that any incomplete/inaccurate information may result in back taxes and/or penalties imposed by the Internal Revenue Code. A copy of the PTS Deferred Compensation Retirement Plan Employee Information Booklet has been given to me. I understand that I will not contribute to Social Security, but will contribute to Medicare. I understand that 7.5% of my gross wages shall be deducted pre-taxed from each paycheck and deposited into the PTS Deferred Compensation Retirement Plan.

_____	_____	_____
Employee's Signature	Employee's Name (print)	Date

The Plan Booklet can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. For more information, please call CFP/LSW at 808-596-7006 (Neighbor Islands call toll-free at 1-800-600-7167).