(EMPLOYER NAME)

SECTION 403(b) TDA PLAN CONTRIBUTION ELECTION FORM

EMPLOYEE NAME _____ SOCIAL SECURITY NUMBER _____

The 403(b) TDA Plan has been explained to me and I have received a description of the plan. I understand that I may voluntarily choose to have my pay reduced for contributions to the plan.

ELECTION TO CONTRIBUTE

I elect to contribute _____ % or $ _____ of my pay and authorize my employer to deduct that amount each pay period. I am aware that my contribution may be reduced in order to comply with federal tax rules and limits, including any higher limits that apply to participants age 50 or older. I also understand that this election will take effect with the first pay period beginning on or after the first day of the next month beginning a reasonable time after I file this election with my employer. I may stop or change my election for future pay periods by giving my employer written notice, which notice will be given effect as soon as administratively feasible.

I am aware that my contributions and earnings cannot be withdrawn or paid until I attain age 59-1/2 or upon my death, disability or termination of employment. My contributions may be available in the event of serious financial hardship (according to the plan and IRS rules).

EMPLOYEE SIGNATURE _____ DATE _____

ELECTION NOT TO CONTRIBUTE

I do not wish to contribute to the plan at this time. I understand that, if the plan provides for matching employer contributions, I will not be entitled to such contributions during the time I am not contributing. I also understand that I may elect to contribute in the future by completing a contribution election form and an enrollment form and filing them with my employer.

EMPLOYEE SIGNATURE _____ DATE _____

EMPLOYER REPRESENTATIVE _____ DATE RECEIVED _____

NOTE TO EMPLOYERS

THIS FORM SHOULD BE RETAINED WITH THE EMPLOYER'S RECORDS OF THE PLAN

EMPLOYERS SHOULD REVIEW THIS SAMPLE PAYROLL AUTHORIZATION FORM WITH COUNSEL REGARDING ANY APPLICABLE STATE LAW THAT MAY AFFECT THIS DOCUMENT.

MUTUAL OF AMERICA

Tax-Deferred Annuity EMPLOYEE ENROLLMENT FORM

EMPLOYER INFORMATION

EMPLOYER'S NAME | EMPLOYER NUMBER

EMPLOYER'S ADDRESS | City | State | Zip Code

DATE EMPLOYEE HIRED / / | EMPLOYEE'S SALARY RATE $ | ☐ Annual ☐ Monthly ☐ Semimonthly ☐ Biweekly ☐ Weekly

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER | EMPLOYEE'S NAME First Initial Last

MAILING ADDRESS Street (Include Apartment Number) | City | State | Zip Code

IF FOREIGN RESIDENT | Province | Country

DATE OF BIRTH	☐ MALE ☐ FEMALE	INITIAL CONTRIBUTION	DEPARTMENT # (Optional)	DISTRIBUTION #	TELEPHONE NUMBERS HOME	OFFICE
/ /		$		1937	( )	( )

The following three items need be completed only if you are employed by an educational institution.

Contributions will be made: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

☐ No paychecks are distributed during the following period: _____

☐ Paychecks are distributed throughout the year.

ALLOCATION OF CONTRIBUTIONS

Show the percentage of your contributions you want to place in the interest account and/or investment funds. Use whole numbers only, and make sure the percentages total 100%.

Amounts you place in the interest account will be credited with the rate of interest currently applicable to that account. Your balance in any investment fund will fluctuate to recognize investment results.

INTEREST ACCOUNT					
MUTUAL OF AMERICA					
Interest Accumulation Account %					
INVESTMENT FUNDS					
OPPENHEIMER					
Main Street Fund®/VA %					
CALVERT					
Social Balanced Fund %					
AMERICAN CENTURY					
VP Capital Appreciation Fund %					

INVESTMENT FUNDS				
MUTUAL OF AMERICA				FIDELITY®
Money Market Fund %	All America Fund %	2015 Retirement Fund %		VIP Asset Manager℠ Fund %
Mid-Term Bond Fund %	Small Cap Value Fund %	2020 Retirement Fund %		VIP Mid Cap Fund %
Bond Fund %	Small Cap Growth Fund %	2025 Retirement Fund %		VIP Equity-Income Fund %
Composite Fund %	Mid Cap Value Fund %	2030 Retirement Fund %		VIP Contrafund® %
Conservative Allocation Fund %	Mid-Cap Equity Index Fund %	2035 Retirement Fund %		VANGUARD
Moderate Allocation Fund %	International Fund %	2040 Retirement Fund %		Diversified Value Fund %
Aggressive Allocation Fund %	Retirement Income Fund %	2045 Retirement Fund %		International Fund %
Equity Index Fund %	2010 Retirement Fund %			
DWS				
Bond Fund %	Capital Growth Fund %	International Fund %		

EMPLOYEE MUST COMPLETE REVERSE SIDE

BENEFICIARY DESIGNATIONS

In the event of your death, the total value of your account is to be paid to the person or persons named below. If any such person predeceases you, the portion that would have been payable to him or her will be paid to the other person or persons named.

If you name more than one primary beneficiary, or more than one secondary beneficiary, the death benefit will be paid in equal shares unless you show the percentage you want each of them to receive. If you do this, make sure your figures for each beneficiary type total 100%.

If no one you have named as a primary beneficiary is living when the death benefit is to be paid, the person(s) you name as your secondary beneficiary will receive the death benefit. If no one you have named as a primary or secondary beneficiary is living at your death, the amount payable will be paid in the following order: to (a) your widow or widower, (b) your children in equal shares, (c) your parents in equal shares, (d) your brothers and sisters in equal shares, or (e) the executors or administrators of your estate.

Name your primary and secondary beneficiaries in the space provided below. If you need more space, attach a page showing for each beneficiary the necessary information. Please add your Employer's name and Employer number, your signature and the date.

Beneficiary Type: [X] Primary **Relationship:** [ ] Spouse [ ] Child [ ] Parent [ ] Estate [ ] Other		**Beneficiary Type:** [ ] Primary [ ] Secondary **Relationship:** [ ] Spouse [ ] Child [ ] Parent [ ] Estate [ ] Other	
FULL NAME First Initial Last		FULL NAME First Initial Last	
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)	DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)
ADDRESS Street		ADDRESS Street	
City State Zip Code		City State Zip Code	
IF FOREIGN RESIDENT Province Country	BENEFIT PERCENT %	IF FOREIGN RESIDENT Province Country	BENEFIT PERCENT %

SPOUSE'S WAIVER (Witnessed by a Notary Public or Authorized Representative of Employer)

The Spouse's Waiver below must be completed if you are married and naming a person other than your spouse as your primary beneficiary and you are enrolling in a Tax-Deferred Annuity that your plan description describes as a plan that is subject to the spousal consent rules of ERISA.

I understand that under Mutual of America's contract, I am entitled to be my spouse's beneficiary. As the beneficiary, I would receive a death benefit after my spouse's death. However, I agree to waive my right to be the beneficiary. I agree to let my spouse designate the beneficiary or beneficiaries named on this form.

_____ _____

Signature of Spouse Date

_____ _____

Signature and Seal of Notary Public or Signature of Authorized Representative Date

STATEMENT AND SIGNATURE

I have read the current prospectus and other materials describing the contract, and after careful consideration I have found the contract to be suitable for my financial needs. Therefore, I elect to participate in the TDA.

Signature	Date