2520140933351

THE COLONIAL DAMES OF AMERICA
417-421 EAST 61st STREET
NEW YORK, NY 10021-8736
(212) 838-5489 • Fax (212) 688-1389

To: Top Hat Plan Exemption
Pension and Welfare Benefits Administration
Room N-5644
US Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

In accordance with 29 CFR Section 2520.104-23 of the Department of Labor Regulations, which provides an alternative method for complying with the reporting and disclosure requirements of Part 1 of Title I of the Employee Retirement Income Security Act of 1974, you are hereby notified that the Employer identified below maintains the **Plan 457(b)** identified below for the purpose of providing deferred compensation for a select group of management or highly compensated employees, and that all benefits provided by Plan 457(b) are paid as needed solely from the general assets of that Employer.

Employer's Name: Deidre L. Bay.

Employer's Address: 440 East 56th Street, Apt. 5-G.

New York, New York, 10022.

Employer Identification Number: 13-1677400.

Plan 457(b), which covers 1 Participant.

Total Number of Plans: 1.

The Colonial Dames of America
Plan Administrator of the Plans Specified Above

By: Shirley Dixon Miller
Shirley Dixon Miller, Treasurer.

Date: February 3, 2005.

Copy of employee enrollment to MUTUAL of AMERICA 457 PLAN

ALTERNATIVE REPORTING AND DISCLOSURE STATEMENT FOR A NONQUALIFIED DEFERRED COMPENSATION PLAN

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SPECIMEN
Participant Enrollment Agreement

For Eligible Employees of COLONIAL DAMES of AMERICA ("Employer")
(NAME OF EMPLOYER)

EMPLOYEE NAME DEIDRE L. BAY		
EMPLOYEE ADDRESS 440 East 56th St., Apt 5-G	CITY New York	NY 10022

I have received and read a copy of the 457(b) Eligible Deferred Compensation Plan established and maintained by my Employer (the "Plan"). I understand that I am an Eligible Employee and I agree to participate in the Plan in accordance with its provisions, including the deferral of Compensation on my behalf by my Employer. I understand that no deferrals can be made by me, or on my behalf by my Employer until I have completed this form and returned it to my Employer.

BENEFICIARY DESIGNATIONS

I designate the following person(s), trust or entity as my Beneficiary(ies) with respect to any distributions that may be payable under the Plan upon my death.

FULL NAME First: Eugene	Initial: A.	Last: BAY		
ADDRESS Street: 440 East 56th St, #5-G				
City: New York	State: NY	Zip Code: 10022		
IF FOREIGN RESIDENT	Province	Country	RELATIONSHIP: Husband	
AGE (Optional): 71	BENEFIT PERCENT: 100 %			

FULL NAME First	Initial	Last		
ADDRESS Street				
City		State	Zip Code	
IF FOREIGN RESIDENT	Province	Country	RELATIONSHIP	
AGE (Optional)	BENEFIT PERCENT %	SOCIAL SECURITY # (Optional)		

For use with an IRC Section 457(b) Eligible Deferred Compensation Plan of a Tax-Exempt Employer
THIS FORM IS TO BE RETAINED BY THE EMPLOYER
PLEASE BE SURE TO COMPLETE THE REVERSE SIDE OF THIS FORM

MUTUAL OF AMERICA LIFE INSURANCE COMPANY
320 PARK AVENUE NEW YORK NY 10022-6839 • 800 468 3785
www.mutualofamerica.com

Individual Annuity (Non-IRA) APPLICATION

TYPE OF ANNUITY CONTRACT (Choose one)

- [ ] Flexible Premium Deferred Annuity (FPA)
- [x] 457(b) Eligible Tax-Exempt Deferred Compensation Plan
- [ ] 457(f) Ineligible Tax-Exempt Deferred Compensation Plan
- [ ] Other Nonqualified Deferred Compensation Plan

ANNUITANT'S INFORMATION

ANNUITANT'S NAME: DEIDRE L. BAY

ANNUITANT'S TELEPHONE NUMBER: WORK (212)838-5489 HOME (212)935-3298

ANNUITANT'S ADDRESS: 440 East 56th St, 5-G City: New York State: NY Zip Code: 10022

- [ ] MALE
- [ ] FEMALE

INITIAL CONTRIBUTION: $

DISTRIBUTION #: 1937

CONTRIBUTION METHOD: Check

- [ ] DIRECT PAYMENT
- [x] PAYROLL DEDUCTION

OWNER'S INFORMATION (Complete if Owner is not the Annuitant)

OWNER'S NAME

OWNER'S TELEPHONE NUMBER: WORK HOME

OWNER'S ADDRESS City State Zip Code

OWNER'S TAX OR SOCIAL SECURITY NUMBER

EMPLOYER'S INFORMATION (Complete only if payroll deduction)

EMPLOYER'S NAME: COLONIAL DAMES of AMERICA

EMPLOYER NUMBER: 13-1677400

EMPLOYER'S ADDRESS: 417-421 East 61st St City: NY State: NY Zip Code: 10021

EMPLOYER'S TELEPHONE NUMBER: (212)838-5489

CONTRACT INFORMATION

- If a 457 or other deferred compensation plan, the Owner must be the Employer or Trustee.
- First of month that annuity payments are to begin (the Owner may change this date at any time by advance notice) ____ / ____ (optional) (MONTH) (YEAR)
- Is the contract requested by this application intended to replace or change any insurance or annuities now in force?

[ ] Yes [x] No If the answer is "Yes," please provide the following for the policy being replaced or changed:

Company ____________ Contract Number ____________ Amount $ ________

ALLOCATION OF CONTRIBUTIONS

Show the percentage of your future 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	100 %

INVESTMENT FUNDS

MUTUAL OF AMERICA								SCUDDER	
Money Market Fund	%	All America Fund	%	Equity Index Fund	%	Conservative Allocation Fund	%	Scudder Capital Growth Fund	%
Short-Term Bond Fund	%	Mid-Term Bond Fund	%	Bond Fund	%	Moderate Allocation Fund	%	Scudder Bond Fund	%
Composite Fund	%	Aggressive Equity Fund	%	Mid-Cap Equity Index Fund	%	Aggressive Allocation Fund	%	Scudder International Fund	%
FIDELITY						**AMERICAN CENTURY**		**CALVERT**	
Fidelity VIP Asset Manager Fund	%	Fidelity VIP Equity-Income Fund	%	Fidelity VIP Contrafund	%	American Century VP Capital Appreciation Fund	%	Calvert Social Balanced Fund	%

COMPLETE REVERSE SIDE

Please name one or more beneficiaries to receive any death benefits payable. Only you, the Owner may name and change the beneficiary. If th contract will be issued to an employer or trustee in connection with a 457 or other deferred compensation plan, the Owner must be designated as th beneficiary. If you wish to name an organization or an estate to receive any benefits payable, show the name of the organization or the estate in th section labeled "FULL NAME" in the portion of this form provided for naming beneficiaries.

Upon your death or the death of the Annuitant, benefits will be paid to the primary beneficiary(ies). If no primary beneficiary(ies) is (are) living the time benefits become payable, Mutual of America will pay the benefits to the secondary beneficiary(ies). If benefits are to be paid to more tha one beneficiary they will be paid in equal shares, unless other proportions are stated in the section labeled "BENEFIT PERCENT" in the portic of this form provided for naming beneficiaries.

BENEFICIARY DESIGNATIONS

PRIMARY BENEFICIARY OR BENEFICIARIES

I, the Owner, name the following person or persons as my beneficiary or beneficiaries.

FULL NAME First	Initial	Last	FULL NAME First	Initial	Last
COLONIAL DAMES of America					
ADDRESS Street			**ADDRESS** Street		
417-421 East 61st St					
City	State	Zip Code	City	State	Zip Code
NY	NY	10021			

BENEFIT PERCENT	DATE OF BIRTH (Optional)	SOCIAL SECURITY # (Optional)	RELATIONSHIP	BENEFIT PERCENT	DATE OF BIRTH (Optional)	SOCIAL SECURITY # (Optional)	RELATIONSHIP
100 %	/ /			%	/ /		

SECONDARY BENEFICIARY OR BENEFICIARIES

If none of the persons named above is living when a payment is to be made, the following person or persons are to receive the payment

FULL NAME First	Initial	Last	FULL NAME First	Initial	Last
ADDRESS Street			**ADDRESS** Street		
City	State	Zip Code	City	State	Zip Code

BENEFIT PERCENT	DATE OF BIRTH (Optional)	SOCIAL SECURITY # (Optional)	RELATIONSHIP	BENEFIT PERCENT	DATE OF BIRTH (Optional)	SOCIAL SECURITY # (Optional)	RELATIONSHIP
%	/ /			%	/ /		

STATEMENT AND SIGNATURE

I, the Owner, acknowledge that: (a) I have received a copy of the current Prospectus; (b) I have read the Prospectus and understand its term and (c) I am familiar with the objectives of the Investment Funds. I understand that any election or authorization made under my contract part of this application is subject to the conditions and limitations set forth in the Prospectus.

I UNDERSTAND THAT: (A) ANY AMOUNTS PLACED IN THE INTEREST ACCUMULATION ACCOUNT WILL EARN INTERES AT THE RATES DETERMINED BY MUTUAL OF AMERICA; AND (B) ANY AMOUNTS PLACED IN THE INVESTMENT FUNI ARE NOT GUARANTEED AS TO FIXED DOLLAR AMOUNTS AND MAY INCREASE OR DECREASE IN VALUE BASED UPO THE FUNDS' INVESTMENT RESULTS.

All statements in this application are true and complete to the best of my knowledge and belief. I agree that this application will become part of any contract issued based upon this application.

I have determined that the annuity contract applied for above is suitable to: (a) my investment objectives; and (b) my financial situatio

An initial contribution of $ 4200.00 is submitted with this application. I understand that this contribution will be refunde by Mutual of America if a contract based upon this application is not issued.

Signed at New York, NY on February 3, 2005
(City/State) (Month/Day) (Year)

Heidi L Bay
Signature of Owner

Countersigned _____
Authorized Agent

Heidi L Bay
Signature of Annuitant (if other than Owner)

CONSULTANT'S REPORT

To the best of your knowledge is the contract applied for intended to replace insurance or annuity in force in this or any other company?

☐ Yes ☐ No

If "Yes," give company name: _____

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