



This form may be returned by mail: P.O. Box 35236 • Fayetteville, NC 28303 or by fax to: (910) 678-8550

Current 403(b) Plan Information is available at: http://www.faytechcc.edu/emp_benefits/Other_Retirement_Info.asp

403(b) SALARY REDUCTION AGREEMENT

Employee Name: _____ SSN: _____
First Name MI Last Name

Work E-mail Address: _____ Work Phone: _____

Cancellation Request. Please stop my current salary reduction contributions effective: _____

Catch-Up Request. I am currently age 50 or older and would like to take advantage of the special Age 50 catch-up election. I understand this election limit may change from year to year, and that my contribution amount under this election **will not** automatically adjust each year due to changes in the applicable limits. Any changes to my deduction amounts require a new authorization form. *(Also complete the New / Change Enrollment section below).*

Date of Birth: ____ / ____ / _____

Enrollment Coordination. I also make contributions to the NC State 401(k) plan through this employer. I understand that contribution limits must be coordinated between these two plans to avoid excess deferrals. Allowable limits may change from year to year.

New / Change Enrollment. I wish to contribute the following amount on a pre-tax basis to my 403(b) account established at the vendor indicated below. This election replaces any previous elections that I may have made.

\$ _____ per pay period Effective date: _____

To Vendor: _____

I understand this election will remain in effect until I request a change in writing. However, I acknowledge and agree that my employer may reduce or suspend my contributions if it is determined that the legal limit has been reached, and will return any excess contributions to me.

I understand it is my sole responsibility to establish an account with the selected vendor and to monitor investment performance, fees and expenses associated with the account that I choose to establish. I agree to make in-service exchanges only among vendors currently authorized to receive such exchanges under my employer's Plan. I understand that this agreement does not restrict my ability to make transfers or direct rollovers of eligible rollover distributions from the Plan to another eligible retirement program after I have separated from employment.

I understand that participation in the Plan may require that account information be coordinated between vendors and my employer. I hereby consent to the sharing of information about my account with my employer, and with the company appointed by my employer acting as data aggregator, for the purposes of compliance with tax requirements, plan administration, or for the approval of distributions, such as loans and hardship withdrawals, if available.

Participant Authorization

By signing below I certify that I have not taken a financial hardship distribution from any existing 403(b) account with-in the past six months, and that I understand I am not eligible to make salary deferral contributions for a six-month period following any such financial hardship distribution.

Employee Signature

Date

Employer Use:

Accepted By: _____ Date: _____ Print Name: _____