

403(b) Salary Reduction Agreement



1 Personal Information

Participant Name _____		Employer Name _____	
Participant Mailing Address, City, State, Zip Code _____			Phone Number _____
Date of Birth _____	Date of Hire _____	Email Address _____	Social Security Number (required) _____

2 Salary Reduction

The Salary Reduction Agreement (SRA) is to be used to establish, change, or cancel salary reduction withheld from your paycheck and contributed to the 403(b) plan on your behalf. To change, begin, or cancel contributions, enter your desired amount(s) and investment provider(s). **This SRA will cancel and replace any previously submitted SRA. You must list all new and existing deductions on this SRA form or they will be cancelled.** The salary reductions identified in the space below will be the only deductions performed starting on the Effective Date.

Investment Provider Name*	Per Pay Period Amount	Type of Deferrals		Requested Action		Effective Date**
		Pre-Tax 403(b)	Other	<input type="checkbox"/> New <input type="checkbox"/> Change	<input type="checkbox"/> Existing <input type="checkbox"/> Cancel	
_____	\$ 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> New <input type="checkbox"/> Change	<input type="checkbox"/> Existing <input type="checkbox"/> Cancel	_____
_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> New <input type="checkbox"/> Change	<input type="checkbox"/> Existing <input type="checkbox"/> Cancel	_____
_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> New <input type="checkbox"/> Change	<input type="checkbox"/> Existing <input type="checkbox"/> Cancel	_____

*Please Note: Certain investment providers may not pay the administration fee. **If you select an investment provider that does not pay the administration fee, the fee will be deducted and paid from your salary reduction amount.** Please refer to the approved vendor list at www.nbsbenefits.com/403b for a current listing of providers that have agreed to pay the fee.

**Please make the SRA due date for your district the effective date. Any other date will defer to the next calendar SRA date.

3 Financial Advisor/Agent Information

Financial Advisor/Agent Name _____	Financial Advisor/Agent Phone Number _____
Financial Advisor/Agent Email Address _____	Financial Advisor/Agent Fax Number _____

4 Employee Approval

I understand and agree to the following:

1. This Salary Reduction Agreement (Agreement) is an agreement between me and my employer that I have entered into voluntarily.
2. This Agreement supersedes and replaces all prior Salary Reduction Agreements.
3. The Agreement is legally binding and irrevocable with respect to amounts paid or available while this agreement is in effect.
4. The Agreement may be terminated or modified at any time for amounts not yet paid or available.
5. Nothing herein shall affect the terms of my employment with the Employer.
6. This Agreement shall automatically terminate if my employment is terminated.
7. If the Salary Reduction Agreement is received less than 5 business days prior to the SRA due date, it is not guaranteed to be processed for that SRA due date.

I authorize the automatic cancellation of this Salary Reduction Agreement in the event of any of the following: (1) if either my employer or National Benefit Services, LLC (my employer's third-party administrator) believe additional contributions will cause me to exceed limits under Code Section 415 or 402(g), (2) if I take a hardship distribution, if available, or (3) if I take an unforeseeable emergency distribution, if available.

I have read and understand the information contained on page 1 of this Agreement. I understand that by making this application the release of my confidential information to third parties may occur as necessary to administer the Plan in accordance with the Internal Revenue Code.



Employee Signature _____	Date _____
--------------------------	------------