



**SALARY REDUCTION ENROLLMENT AND AMENDMENT FORM**

# 457 Deferred Compensation Plan – PRE TAX

Pursuant to the provisions and conditions set forth on the bottom of this page, I hereby request and authorize the Payroll Department of \_\_\_\_\_ to reduce my salary by, or in the event of an after tax contribution, to deduct from my salary, the amount indicated in Section A of this form and direct the amount of such reduction/deduction to the company indicated in Section C below.

**SECTION - A**

Employee Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Work Site: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Employee Contribution per Pay Period: \$ \_\_\_\_\_  10 Pay  11 Pay  12 Pay  Other \_\_\_\_\_

Effective Date of Change: \_\_\_\_\_ Employee Annual Contribution: \$ \_\_\_\_\_

**SECTION – B: CHECK ALL THAT APPLY:**

Initial Enrollment  Dollar Change  Beneficiary Change  Investment Change  Stop all contributions

**SECTION – C: INSURANCE COMPANY/MUTUAL FUND TO RECEIVE 457(B) CONTRIBUTIONS:**

Name of Company: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Per Pay Period

Company Address: \_\_\_\_\_

Name of Company: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Per Pay Period

Company Address: \_\_\_\_\_

**SECTION – D**

**KEY: PS=PER STIRPES**

**PC=PER CAPITA**

**Primary Beneficiary(s):** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ % \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ % \_\_\_\_\_

**Contingent Beneficiary(s):** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ % \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ % \_\_\_\_\_

**SALARY REDUCTION / DEDUCTION AMENDMENT TO EMPLOYMENT CONTRACT**

I hereby agree to the terms of the Plan Agreement.

I hereby authorize my employer to deduct from my salary the amount specified above and to transmit the deduction to the above designated company or companies. This authorization will continue in effect until I submit a timely termination.

By signing this document, the Employee directs the to withhold at the above level and acknowledges that he/she has been advised by qualified tax counsel and agrees to indemnify and hold the District/Employer harmless from any and all taxes, penalties, and cost which may occur due to any over-withholding of tax sheltered annuity funds generated by this amendment to the employment contract.

The Employee hereby both authorizes the disbursing agent to recover any amount erroneously transmitted by it, from the company(ies) receiving the erroneous amount, and directs the company(ies) so affected immediately transmit those amounts to the disbursing agent.

The Employees agrees that the District/Employer shall have no liability whatsoever for any and all losses suffered by the Employee with regard to his/her selection of the investment; the terms of the investment; the selection of the insurance company or regulated investment company; the solvency of, operation of or benefits provided by said insurance company or regulated investment company; or his/her selection and purchase of shares of regulated investment companies.

The employer and the employee are the sole participants in the Plan.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Advisor Name (if applicable): \_\_\_\_\_

Phone: \_\_\_\_\_

District/Employer Authorization: \_\_\_\_\_

Date: \_\_\_\_\_