



403b/457 Salary Reduction Agreement

First	Middle	Last Name	Social Security #	Date of Birth
Home Address		City	Telephone #	Cell phone #
State	Zip Code	Email Address	Date of Hire	
Effective Date of Change Specified Date ____-____-____ or Earliest Pay Cycle Possible			# deductions per year 9 10 12 other ____	School Location Phone #

Vendor Name	Product Name	Product Type 403B Roth 403B 457	Deduction Amount	Action Desired N-New S-Stop E-Existing I-Increase D-Decrease
1. Annuity Investors , Inc	Great Flex 7 Flex Max 6 Individual Amer-Achieve	403B/Roth 403B 403B/Roth 403B 457		
2. ING	Quintaflex	403B		
3. Horace Mann	Group Variable Annuity Group Fixed Annuity	403B 403B		
4. Lincoln Investment	Retirement Solutions Retirement Sol Premier	403B 457 403B 457		
5. Pacific Life	Value VA	403B		
6. Grandfathered Vendor	Product Name If Known			
7. Prudential Securities	NC 401K	401K		



Vendor/product/product type/deduction amount and action desired MUST be completed for each plan deduction that you wish to have remitted to a vendor. Information must be complete. **INCOMPLETE INFORMATION WILL BE RETURNED TO THE SALES REPRESENTATIVE FOR COMPLETION BEFORE MAKING CHANGES.**

Total Deduction \$ _____

I understand and agree to the following:

1. This agreement cancels all previous agreements and will remain in force, as long as I am an eligible employee, until modified or canceled by a new salary reduction agreement (SRA) being completed and submitted by the payroll deadline.
2. I authorize the employer to reduce or suspend any contributions established by this agreement, if in its opinion; the total annual contributions would exceed my Maximum Allowable Contribution in any calendar year, or as otherwise provided by the Plan.
3. I authorize my Employer to obtain information from the issuers of the annuity contracts and custodians of the custodial accounts for purposes relating to the maintenance or administration of the Plans.
4. I acknowledge that my Employer has made no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the annual and/or custodial account here within. I agree my Employer shall have no liability whatsoever for any and all losses suffered by me with regard to my selection of the annuity and/or custodial account, its terms, the selection of the insurance company, custodian, or regulated investment company, the financial condition, operation of or benefits provided by said insurance company, custodian, or regulated investment company, or my selection and purchase of shares of regulated investment companies.
5. I am permitted to modify the above listed amounts which are remitted to each annuity contract or custodial account, and such modification may only be affected by my completing and forwarding the payroll office a new Salary Reduction Agreement. Any modifications I make may be subject to limitation by rules or regulations of the issuers of the annuity contracts and custodians of the custodian accounts, as well as any IRS and Treasury rules and regulations.
6. The Third Party Plan Administrator for Alexander County Public Schools is Great American Plan Administrators, Inc. PO B0x 60 Cincinnati, OH 45201-0060. Toll free number is 800-695-1471. Fax number is 513-357-3199. Website address is: www.gaplandata.com. My employer will forward the deductions listed above to Great American Plan Administrators Inc. Great American Plan Administrators will forward the deductions to respect vendors on my behalf in a timely manner pursuant to the procedures establish by my employer.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY SALES REPRESENTATIVE

I agree to comply with all pertinent written directives regarding the allocation of requests of Employees.



700 Liledoun Road Taylorsville NC 28681

Sales _____

Representative Name _____ Date: _____

Signature: _____ Phone: _____

Representative's Mailing Address _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

Employer Confirmation Signature _____ Date: _____