Cecil County Public Schools 403(b) Deferred Compensation Plan

Salary reduction agreement - One time Sick / PTO Payout CCBE-002

Step 1: Participant information

Information provided on this form will be used exclusively for administering your account and sending financial documents and information related to your plan.

Name ______________________________ SSN ______-______-______
First Middle Last Suffix (i.e., Jr., Sr.)

Address ______________________________

City ______________________________ State ____________ Zip ____________

Birthdate ____ / ____ / ______ *(mm/dd/yyyy)* ☐ Married ☐ Not married Daytime phone ____________

Date of hire/rehire ____ / ____ / ______ *(mm/dd/yyyy)* ☐ Male ☐ Female Evening phone ____________

Step 2: Decide how much to contribute

All percentages are required to be whole numbers (i.e., 3%, 5%).

I elect to defer the following percentage into the Cecil County Public Schools 457(b) Deferred Compensation Plan upon payment of my unused sick pay and/or unused PTO pay:

☐ **Unused SICK Pay** **I elect to contribute this percentage:** Pretax ________% Roth ________%

☐ **Unused PTO Pay** **I elect to contribute this percentage:** Pretax ________% Roth ________%

Please complete the remainder of the form.

Step 3: Employee acknowledgement

By signing this agreement below, you acknowledge and agree to the following:

- The employer will reduce your pay by the amount indicated (in Step 2 above) for the one-time pay-out. The employer will send this amount to the provider as contributions.
- The deduction will take place as soon as administratively possible after we receive this form.
- This agreement legally binds both you and the employer for amounts deferred while it is in effect. A new agreement must be submitted to change your deferral percentage.
- This agreement will apply only to amounts not yet currently available to you. It will not apply to any amounts earned after the agreement is terminated.
- If you do not provide investment choices, your contributions will be invested in the default fund chosen by your employer.

Step 4: Signatures

By signing below you certify that you have read, understand and agree to the terms on this form. The signature of the plan administrator certifies that the plan administrator has read, understands and agrees to the terms on this form.

Participant signature ______________________________ Date ____ / ____ / ______ *(mm/dd/yyyy)*

Plan administrator signature ______________________________ Date ____ / ____ / ______ *(mm/dd/yyyy)*

Return this form to: Your employer's Human Resources department.