OMNI&TSACG Compliance Services

Visit Us Online: https://www.omni403b.com

220 Alexander Street, Suite 400 Rochester, NY 14607 Phone: 1.877.544.6664 Fax: 1.585.672.6194

457 SALARY REDUCTION AGREEMENT FORM (SRA) For Tax Sheltered Annuities and Custodial Accounts

- **Please supply the information requested below.**
- **Read all agreements on this form before submitting.**
- **Fields having an asterisk notation are required.**

457

IMPORTANT NOTICE: Before You Sign, Read All Information on this form:
A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed $22,500 ($30,000 if age 50 or over) in 2023. Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information

☐ Check here if you have contributed to another 457 plan offered by another employer in the current calendar year. **NOTE: Do not check this box if you have only contributed to the 457 plan associated with this SRA**. If so, please provide the amount of the year-to-date contributions you have made to the other plan(s):
$ ______ and, if applicable, the name of the other Plan: ______

* Social Security Number: ______ * First Name: ______ MI: ___ * Last Name: ______

* Address: ______

* City: ______ *State: ___ *Zip: ______

* Date of Birth: ______ * Phone: ______ * Email address: ______

Part 2: Employer Information

* Full Organization Name, City and State: ______ * Date of Hire: (mm/dd/yyyy) ______

Part 3: Contribution Information

OPTION 1: Recurring Contributions

WARNING!!! Any new recurring contributions will supersede all current recurring contributions to your employer's 457 plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 457 plan, please be sure to list all contributions you wish to continue. Any active 457 contributions found in our records, but not listed below WILL BE DISCONTINUED.

If you simply wish to discontinue a contribution, fill in an amount of zero.

Please withhold funds from my pay for the following 457 contributions until further notice:

Plan Type		Service Provider	Account #	Effective Date	Amount Per Pay	OR	Percent Per Pay Period
☐ 457	☐ ROTH 457						
☐ 457	☐ ROTH 457						
☐ 457	☐ ROTH 457						
☐ 457	☐ ROTH 457						

If you have requested a percentage amount for any of the contributions above, please supply:
Your Annual Salary: ______ Number of Pay Periods Per Year: ______
☐ Please check here if you are NOT a full-time employee

OPTION 2: One-Time Contributions (Elective Contributions Only)

Plan Type		Service Provider	Account #	Effective Date	Amount	After this contribution, any 457 recurring contributions to this service provider should be:	
☐ 457	☐ ROTH 457					☐ DISCONTINUED	☐ RESUMED
☐ 457	☐ ROTH 457					☐ DISCONTINUED	☐ RESUMED
☐ 457	☐ ROTH 457					☐ DISCONTINUED	☐ RESUMED
☐ 457	☐ ROTH 457					☐ DISCONTINUED	☐ RESUMED

☐ Please check here if you are NOT a full-time employee

OPTION 3: Participation Opt Out

☐ **I do not wish to participate at this time.** I understand that I may participate in the future by filling out a new Salary Reduction Agreement form.

Continued on next page...

Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.
   (b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.
   (c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.
   (d) (i) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of any service provider, the financial condition, operation of or benefits provided by said service provider, or his/her selection and purchase of shares by any service provider. Nothing herein shall affect the terms of employment between Employer and Employee.
   (ii) Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein.
   (iii) The Employer shall not have any liability for any and all losses suffered by an Employee with regard to the selection(s) of any TSA and/or CA, any related terms and conditions, the selection of any service provider, the financial condition, operation of or benefits provided by any service provider or the selection and purchase of shares by any service provider..
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA.
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. That some service providers may take administration fees from your 457(b) account.
10. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
11. To contact OMNI to start the process on any requests for loans, hardship withdrawals, account exchanges or plan-to-plan transfers.
12. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers.
13. This agreement supersedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my requested salary reduction(s), if in excess of my base limit, represent(s) my wish to utilize any catch-up provisions for which I may be eligible. I further certify that I will notify OMNI in the event I begin contributing to another 457(b) plan. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: ______________________ Date: __________

Part 6: Acknowledgement and Representation of Sales Agent/Representative (Not Required to Submit SRA)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. In the event I provide OMNI with an Employee's date of birth ("DOB"), I acknowledge and agree that I must provide accurate information based on documentation provided to me by the Employee. Furthermore, I understand that any DOB information I provide to OMNI is utilized by OMNI to calculate the Employee's Maximum Allowable Contribution limits, which must be accurate to keep the Employer's plan in compliance with IRS regulations. All indemnification or other responsibility for a claim or demand arising from an error in employee DOB I provide will be governed by the Information Sharing Agreement between my employer and OMNI.

Sales Agent/Representative Name: ______________________ Phone: __________

Email: ______________________

Signature: ______________________ Date: __________

☐ I wish the above named agent to be copied on all e-mail communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction.

Part 7: Employer Acknowledgement (If Applicable)

Salary: __________ # of TSA/CA Pay Periods: __________ Effective Payroll Date: __________

Employer Name & Title: ______________________

Employer Signature: ______________________ Date: __________

Please return this agreement to Omni Financial Group, Inc., unless otherwise advised by your Employer:

Omni Financial Group, Inc.
220 Alexander Street, Suite 400 • Rochester, NY 14607
Toll Free: (877) 544-OMNI • Fax: (585) 672-6194
Please visit our website at **www.omni403b.com**

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ENROLLMENT APPLICATION

Welcome to the New York State Deferred Compensation Plan. The Plan is a voluntary, long-term retirement savings program designed for your retirement needs. The amount you contribute to the Plan is deducted from your pay and any investment returns grow on a tax-deferred basis.

Contributions to the Plan: The minimum contribution to the Plan is 1% of your gross pay (at least $10 per pay period). The maximum contribution you may make in 2022 is $20,500. If you are at least age 50 prior to the end of the current calendar year, you are eligible to contribute a maximum of $27,000. If you are within three years of the date that you are able to retire without a reduction in pension benefits, you may be eligible to make additional contributions. Contact an Account Executive or HELPLINE Representative at 1-800-422-8463 for more information and the forms to use the higher limits.

Pre-Tax Deferrals: The amount you contribute to the Plan will be deducted from your pay on a pre-tax basis for federal and New York State income tax purposes, thereby reducing your taxable income for the calendar year. The investment returns also grow on a tax-deferred basis and income taxes are paid only when money is withdrawn from the Plan.

Roth Contributions: These deductions are made from your pay on an after-tax basis. Contributions grow tax-deferred, but when money is distributed from the Plan, qualifying distributions are not subject to federal or New York State income taxes.

Processing Time Frame: Enrollments are processed upon receipt; however, federal law states that deferrals may not begin before the start of the next calendar month, unless you make your election prior to your first day of service. You may change or cancel your deferral amount at any time, but these changes may also be subject to these timing limits.

Next Steps: Please read the bullets below to understand the basics of the Plan and then complete your application.

I understand that:

- Withdrawals from the Plan may be taken only upon separation from employment, absence due to qualified military service, death, an unforeseeable financial emergency, attainment of age 59½, from an account that has been in inactive status for two years and has a balance of $5,000 or less (inclusive of any outstanding loan balance but exclusive of assets in a rollover account) or as a loan.
- Participation in the Plan is not intended to replace a regular savings program necessary to cover day-to-day unanticipated financial expenses. Plan distributions for "Unforeseeable Financial Emergencies" are strictly regulated by federal laws. Should I need an unforeseeable emergency distribution, the request must be made in writing and detail the circumstances supporting the financial emergency. If my request is denied, I may appeal to the Review Committee.
- I may enroll in the Plan for the purpose of transferring assets from another 457(b) deferred compensation plan, a 403(b), 401(k), 401(a), Keogh plan, a traditional or rollover IRA without becoming an active participant.
- Unless I have opted for a paper statement, I will receive an email notification when my quarterly statement, Quarterly newsletter and investment performance report are available on the Website. Please call the HELPLINE promptly with any changes.
- If my employer has opted to allow Roth contributions, contributions to the Roth account may not be reclassified after made. The investment allocation for Roth contributions will be the same as for any pre-tax deferrals. Distributions of Roth contributions must meet the same withdrawal requirements as pre-tax withdrawals.
- There is an administrative fee deducted from my Plan account on a semi-annual basis as outlined in the Plan's Investment Options Guide. These fees are subject to change.

Information relating to the Plan or a copy of the Plan Document may be obtained by calling the HELPLINE at 1-800-422-8463 or visiting the Plan's Web site at www.nysdcp.com.

Tips for Completing the Application

State Employees

If you are employed by a State Agency, please see the screen shot below to assist you with identifying the information necessary to complete the application.

This application will require you to include your five-digit Department ID, which is located on the upper left corner of your pay stub, and your NYS Employee ID that is listed next to the Department ID. If you do not have this information, your application cannot be processed.

Local Employees

If you are employed by a city, town, or library system that contains its own payroll department, the application requires your Local Plan ID. This six-digit number can be obtained by contacting your payroll department or our HELPLINE at 1-800-422-8463.

Deferral Information

State Employees

When entering your deferral amount, you must provide a percentage of your gross pay. This percentage must be a whole number. If you need assistance calculating a percentage for your deferral, please contact our HELPLINE at 1-800-422-8463.

Local Employees

Before completing your application, please check with your employer or our HELPLINE to find out if your employer requires deferrals to be entered as a dollar amount or as a percentage.

Please note that if you elect a deferral rate of 100%, you are authorizing the Plan to deduct the remaining balance of your paycheck after all other required pre-tax deductions have been taken. If you are electing this deferral percentage for a lump sum payment to the Plan, it is important to contact the HELPLINE with the exact date of the lump sum payment.

FORM RETURN

Return to: New York State Deferred Compensation Plan
Administrative Service Agency
P.O. Box 182797
Columbus, OH 43218-2797

Overnight Address: New York State Deferred Compensation Plan
Administrative Service Agency, 1-LC-F2
1 Nationwide Plaza
Columbus, Ohio 43215-2239

OR Fax to: 1-877-677-4329

When faxing paperwork, please allow two hours for your form to be received.
If your fax is sent after 3:00pm your paperwork will be filed on the next business day.

New York State
Deferred Compensation Plan
A Plan for Your Future

Internal Use Only
Account Executive
#____________

HELPLINE: 1-800-422-8463
ENROLL ONLINE AT WWW.NYSDCP.COM

ENROLLMENT APPLICATION

PERSONAL DATA

Name (Please Print) __________ ☐Male ☐Female SSN __________

Home Address __________ Date of Birth __________

City __________ State __________ Zip __________ Home Telephone Number __________

Employer __________ Work Telephone Number __________

Email Address **(Required- Please see eDelivery section for additional detail)** __________ County of your Employer __________

Employer Codes – Your enrollment cannot be processed without this information. **Complete one box only.**

I am paid through the Office of the State Comptroller (OSC) **New York State Employee ID Number** (Starts with N0) __________ **State Agency ID Code** (5 digit code on left side of paystub) __________	**OR**	**I am paid through a local municipality (local town, village, or school)** **Local Plan ID:**__________ If you are unaware of this number, please contact your Payroll Center or the HELPLINE

DEFERRAL INFORMATION

Prior to making your deferral selection please read the following:

The minimum deferral allowed *is 1% of your gross salary or $10 per pay period.* ***If you select 100% your entire paycheck less any benefit withholdings will be deferred.***

If you are paid through the Office of the State Comptroller (OSC) – You must enter a percentage deferral. **(Whole percentage)**

If your employer is a local town, village, or school:

- Check with your payroll department or the HELPLINE to determine **whether your employer accepts a deferral dollar amount or percentage.** Once determined provide a whole dollar or whole percentage amount below.
- If your employer utilizes OMNI as a third-party payroll administrator, please contact OMNI to complete the enrollment deferral process. **Only your payroll department would be able to confirm if they use OMNI.**

Pre-Tax Deferral: ______% or $: ________ Roth Contributions: ______% or $: ________

If you select both Pre-tax and Roth deferrals the maximum combined deferral percentage cannot exceed 100%.

BENEFICIARY DESIGNATION

Please complete all requested information for each of your primary and contingent beneficiaries. A person **may not** be listed as both a primary and contingent beneficiary. If you select "Equal Percentage" for your beneficiaries, there may be some minor variance based upon the number of beneficiaries you have listed. For example, if you list three beneficiaries, the oldest beneficiary will be designated 33.34% and the other two will be 33.33%. If needed, you may submit additional beneficiary information on a separate sheet in the same format.

- Primary Beneficiary(ies): A primary beneficiary is the person or persons who receive your Plan benefits in the event of your death.
- Contingent Beneficiary(ies): A contingent beneficiary is the person or persons who would receive your Plan benefits if all of your primary beneficiaries predecease you.

Primary Beneficiary (ies) *(must be in whole percentages and total 100%)*

☐ **Equal percentages for each primary beneficiary**

Beneficiary Name	Relationship	Date of Birth	Social Security Number	Percent
				____%
				____%
				____%
				Total = 100%

Contingent Beneficiary(ies) *(must be in whole percentages and total 100%)*

☐ **Equal percentages for each contingent beneficiary**

Beneficiary Name	Relationship	Date of Birth	Social Security Number	Percent
				____%
				____%
				Total = 100%

EDELIVERY OPT OUT

☐By checking this box, I elect to receive my quarterly statements and other confirmations from the Plan by **regular mail**. I understand that by **not** checking this box, I elect eDelivery for quarterly statements, newsletters, investment performance reports and confirmations. With eDelivery, I will be emailed this information at the address provided under the Personal Data section when the information is posted to the Plan's Web site.

DEFERRAL ALLOCATION

Write the percentage you wish to allocate to each investment option. You may allocate your salary deferrals among any of the investment options listed below. The allocation of your contributions may be in any whole percentage and must total 100%.

DO IT FOR ME

The following investment options are professionally managed asset allocation funds based on your expected retirement date:

VRU#

______% (1776) TRP Retirement Date 2010 Trust (CIT)
______% (1777) TRP Retirement Date 2015 Trust (CIT)
______% (1778) TRP Retirement Date 2020 Trust (CIT)
______% (1779) TRP Retirement Date 2025 Trust (CIT)
______% (1780) TRP Retirement Date 2030 Trust (CIT
______% (1781) TRP Retirement Date 2035 Trust (CIT)

VRU#

______% (1782) TRP Retirement Date 2040 Trust (CIT)
______% (1783) TRP Retirement Date 2045 Trust (CIT)
______% (1784) TRP Retirement Date 2050 Trust (CIT
______% (1785) TRP Retirement Date 2055 Trust (CIT)
______% (1786) TRP Retirement Date 2060 Trust (CIT)
______% (2884) TRP Retirement Date 2065 Trust (CIT)

The following core investment options permit participants to create their own asset allocation:

DO IT YOURSELF

Stable Income Fund

______% (2756) NYSDCP Stable Income Fund

Bond Funds

______% (1788) NYSDCB US Debt Index U/A (CIT)
______% (1794) Voya Core Plus Trust Fund (CIT)

Balanced Funds

______% (8957) Vanguard Wellington Fund – Admiral (MF)

Large Cap Funds

______% (1789) NYSDCB Equity Index U/A (CIT)
______% (1787) Boston Partners Large-Cap Value Equity Fund (CIT)
______% (1791) T. Rowe Price Equity Income Trust (CIT)
______% (1792) T. Rowe Price Blue Chip Growth Trust (CIT)
______% (2765) Vanguard PRIMECAP Fund - Admiral (MF)

SMID Cap Funds

______% (1790) NYSDCB Russell 2500 Index U/A (CIT)
______% (653) Vanguard Strategic Equity Fund (MF)

*At a yet TBD date the NYSDCP Active/Passive funds will transition to the corresponding investment shown.

Small Cap Funds

______% (1692) Delaware Small-Cap Value Fund CL I (MF)
______% (1793) T. Rowe Price QM US Small-Cap Growth Equity Fund CL I (MF)

International Funds

______% (2969) Fidelity Int'l Capital Appreciation
______% (5025) NYSDCP Int'l Equity Active / (3006) Principal Diversified International (CIT)*
______% (2082) Fidelity Global ex US Index Fund*

Emerging Markets

______% (1458) MSIF Emerging Markets Portfolio – Institutional (MF)

Specialty Options

______% (1963) Pax Environmental Global Markets Fund – Institutional (MF)
______% (1974) Fidelity OTC Fund – K Shares (MF)

100 % **(MUST TOTAL 100%)**

Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses or factsheets carefully.

AUTHORIZATION

I agree to the terms of the New York State Deferred Compensation Plan. I authorize my employer to deduct the amount or percentage set forth herein until I provide further notice for the purposes of contributing it to my Plan account. I further authorize my employer to process any deferral changes I request through the Plan in the future. Deferrals made by participants who are not New York State residents may be subject to the state income tax in the year deferred in their state of residence. Please read your state income tax instructions carefully.

______________________________ Participant Signature

______________ Date