

403(b) 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.

403(b)

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 \$19,500 (\$26,000 if age 50 or over) in 2020. Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information

Please check here if you have contributed to another 403(b), 401(k) or 401(a) plan this calendar year. 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 supercede all current recurring contributions to your employer's 403(b) plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 403(b) plan, please be sure to list all contributions you wish to continue. Any active 403(b) contributions found in our records, but not listed below WILL BE DISCONTINUED. Also, a contribution may be discontinued by listing it below with an amount of zero.

Please withhold funds from my pay for the following 403(b) contributions until further notice:

Plan Type	Service Provider	Account #	Effective Date	Amount Per Pay	OR	Percent Per Pay Period
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____

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)

After this contribution, any 403(b) recurring contributions to this service provider should be:

Plan Type	Service Provider	Account #	Effective Date	Amount	
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> 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 simply by filling out a new Salary Reduction Agreement form.

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.
(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.
9. 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.
10. To contact OMNI and complete the appropriate OMNI forms for any requests for distributions, loans, hardship withdrawals, account exchanges plan-to-plan transfers or rollover contributions.
11. 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.
12. This agreement supercedes 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 403(b), 401(k) or 401(a) 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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