

§403(b) Plan Administration - §403(b) / §457 Salary Reduction Agreement (SRA)
FOR USE WITH §403(b) OR §457 PLANS ONLY

Important This Salary Reduction Agreement (SRA) **REPLACES AND CANCELS ALL PREVIOUS AGREEMENTS ON FILE**. Only the contributions to the companies listed below will continue after the effective date of this agreement.

Submit this form to The Legend Group/ADSERV Plan Administration Team.

I. Employee Information

Employee _____ Social Security # _____

Employer _____ Date of Birth _____

Email _____ Work Phone # _____

Employee Status: Paid on Salary Basis Hourly Basis

Effective Payroll Date for Salary Reduction: _____ (cannot be less than next pay period)

II. Investment Information

IMPORTANT: You must have an existing §403(b)/§457 account with each investment provider listed, or file an account application with the investment provider, **BEFORE** your first contribution is taken. Please consult your financial advisor.

LIST ALL §403(b)/§457 INVESTMENTS TO CONTINUE AFTER THE EFFECTIVE DATE
 INVESTMENTS NOT LISTED BELOW WILL BE CANCELED AS OF THE EFFECTIVE DATE

Traditional §403(b)	Roth §403(b)	Traditional §457(b) **	Investment Provider	Action Requested:	Amount per Pay Period:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Start <input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Stop	_____% OR \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Start <input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Stop	_____% OR \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Start <input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Stop	_____% OR \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Make a one-time contribution change (prior contribution instructions will resume next pay period)	_____% OR \$ _____
<input type="checkbox"/> I do not wish to participate in the §403(b) Plan at this time.					

III. Other Payroll Remitted Deferrals

IMPORTANT: You must have an existing account with each company listed, or file an account application with the Investment Provider, **BEFORE** your contribution is taken.

	Investment Provider:	Amount per Pay Period:
<input type="checkbox"/> §529 college savings plan	_____ <input type="checkbox"/> New <input type="checkbox"/> Existing	_____% OR \$ _____
<input type="checkbox"/> IRA	_____ <input type="checkbox"/> New <input type="checkbox"/> Existing	_____% OR \$ _____
<input type="checkbox"/> Roth IRA	_____ <input type="checkbox"/> New <input type="checkbox"/> Existing	_____% OR \$ _____

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V. Agreement

The above named Employee elects to become a participant of the Employer's §403(b)/§457 Plan and agrees to be bound by all the terms and conditions of the plan. By executing this agreement, Employee authorizes Employer to reduce his or her compensation and have that amount contributed as an elective deferral to a traditional §403(b)/§457 and/or as a salary reduction contribution to the Roth §403(b) option if permitted in the plan, on his or her behalf into the annuity or custodial accounts as selected by Employee. It is intended that the requirements of all applicable state or federal income tax rules and regulations (Applicable Law) will be met. Employee understands and agrees to the following:

- 1) This Salary Reduction Agreement is legally binding and irrevocable with respect to amounts paid or available while this agreement is in effect;
- 2) This Salary Reduction Agreement 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 Salary Reduction Agreement is submitted; and
- 3) This Salary Reduction Agreement may be changed with respect to amounts not yet paid or available by submitting a new Salary Reduction Agreement, unless indicated otherwise by the Employer in the plan document.

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. Employee agrees Employer shall have no liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the annuity and/or custodial account. Nothing herein shall affect the terms of employment between Employer and Employee. This agreement supersedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Please Note: Employers are responsible for approving only annuity contracts and custodial accounts that meet the requirements of §403(b) of the Internal Revenue Code. The Legend Group/ADSERV will ascertain that the products approved vendors are offering meet these requirements.

Employees are responsible for setting up and signing the legal documents to establish annuity contracts or custodial accounts. However, in certain group annuity contracts, the Employer is required to establish the contract.

Employees are responsible for naming death beneficiaries under annuity contracts or custodial accounts at the time the contract or account is established. Beneficiary designations should be reviewed periodically.

I hereby authorize my 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.

457(b) Contributions – I understand my deferrals cannot begin sooner than the month following Salary Reduction Agreement approval. My accumulated deferrals will be held in trust by my employer for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the plan. I realize I may not assign or transfer my rights under the plan.

**Employee
Signature
(Required)**

X _____
Signature of Employee Date _____

Please forward to The Legend Group/ADSERV Plan Administration Team

P.O. Box 4037 • Fort Walton Beach, Florida 32549

TELEPHONE: (833) 965-0068, Option 5 • FACSIMILE: (866) 908-7582

EMAIL: adserv.sraprocessing@tsacg.com • WEBSITE: <https://adserv.tsacg.com/>

**Completed by
Employer
Payroll Office:
(Not Required)**

Year: _____ Amount: _____ Paycheck Effective Date _____

X _____
Signature of Employer Date _____

**Advisor
Signature:
(Not Required)**

X _____
Signature of Advisor Date _____