Crawford County Community Schools, IN

Participation Agreement for Internal Revenue Code Section 457(b) Deferred Compensation Program

Please Print or Type Legibly--Employees must establish an account with an authorized 457(b) investment provider **PRIOR** to completing this form.

1

Employee Name

Employee Email Address | **Work Location**

Mailing Address

Number of Payrolls Per Year: ☐ 12* ☐ 22* ☐ 24* ☐ 26*

*Reductions will not be withheld for more than two (2) payrolls per month.

2

Employee I.D. Number

Employee Social Security Number

3

☐ **Original Agreement or** ☐ **Amendment to a Previous Agreement or** ☐ **Unused Sick Leave Payout**

4

Reduction Amount

List all companies and salary reductions requested whether new or existing.
IMPORTANT: Read instructions on page 2 of this form.

If effective payroll date is blank, changes will take effect the next processing period after receipt of this from by TSACG.

COMPANY NAME	PAYROLL SLOT NUMBER (if applicable)	SALARY REDUCTION AMOUNT (Dollar Amount)	EFFECTIVE PAYROLL DATE (New account or amendment - MM/DD/YY)	Terminate Reduction
		, .	/ /	☐
		, .	/ /	☐
		, .	/ /	☐
The total amount of contributions to all providers		, .	**for each pay period.**	

NOTICE: Any SRA accounts not listed will be automatically terminated.

The undersigned hereby agrees to the terms and conditions of the **Crawford County Community Schools, IN** Deferred Compensation Plan ("Plan") as such Plan now exists or is hereinafter amended and a copy of the Plan has been made available to them. this election shall continue until the undersigned makes a subsequent election as provided by the Plan.

I (the Employee) understand and agree to the following:

My deferrals cannot begin sooner than the month following Participation Agreement approval. My accumulated deferrals will be held in trust 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.

I am responsible for the accuracy of the excludable amounts stated in the Agreement. Any overstatement of the amounts excludable as a salary reduction in the agreement, or any other violation of the requirements of IRS Code Section 457 could result in additional taxes, interest, and penalties to the Employee.

I hereby authorize my Employer to reduce or suspend any contributions established by this agreement, if in its opinion, the total deferral would exceed the maximum allowable Contribution limit in any calendar year. Should my deferral exceed the maximum limit, I authorize my Employer to disallow deferral of the excess amount and direct these amounts to be refunded to me.

Release of Liability - The Employee agrees that the Employer and its agents 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.

The Employer hereby authorizes on the provider company to issue an annuity contract or custodial arrangement for the benefit of the participant without the signature of the employer provided that the owner of the annuity contract or custodial arrangement is designated as the employer's 457 Deferred Compensation Plan.

Earnings, if any, will be applied to my accumulated deferrals in accordance with the Company and product I have selected. Neither the Employer, nor Trustees, nor agencies of the Employer shall be liable for the performance of the Companies or products selected by the Employee. **Any change to this Agreement must be in writing to the Employer and becomes effective upon the execution of this Agreement by Employee and Employer.**

This Agreement may be terminated by either the Employer or Employee upon thirty (30) days notice to the Company and to the Employer or Employee as applicable.

Designation of Beneficiary - The beneficiary for each annuity contract or certified account to which contributions are allocated shall be determined in accordance with the terms of that specific contract or account.

5

AGENT/REPRESENTATIVE (IF APPLICABLE)-PRINT NAME

AGENT PHONE

EMPLOYER ACCEPTANCE OF AGREEMENT/CONTRACT

6

EMPLOYEE TELEPHONE NUMBER

I agree with the terms above:

EMPLOYEE SIGNATURE

DATE OF THIS AGREEMENT

SRA is not valid if "Effective payroll Date" in Section 4 is more than 90 days from the "Date of this Agreement" in Section 7.

7

Mail or fax your SRA form to:

TSA Administration Services
Attn: SRA Processing Dept.
P.O. Box 4037
Fort Walton Beach, FL 32549

Fax: 1-866-908-7582

Employee Instructions:

1. Complete the Employee sections regarding "Name", "Email Address", "Mailing Address" and "Work Location". Select the number of payrolls* that you, the employee, receive during a calendar year.
2. Enter your "I.D. Number" and/or "Social Security Number" in the boxes provided.
3. Mark the box that corresponds with the type of SRA you are submitting: "Original Agreement" or "Amendment to a Previous Agreement".
4. (a) Enter the information for ALL your new and/or existing accounts (you may have only one account or multiple accounts).
   NOTICE: any SRA accounts not listed will be automatically terminated.
   (b) In addition to entering the company name, the employee and/or agent MUST fill in the correct corresponding Assigned Payroll Slot Code (if applicable) on the SRA list available with this SRA or online at https://www.tsacg.com/employee_site/districts
   (c) Enter the salary reduction amount (dollar amount) you wish to be withheld from your payroll.
   (d) Enter the month or payroll date that you wish your elections (new account or amendment) to be effective.
   (i) If effective payroll date is blank, changes will take effect the next processing period after date of receipt of this form by TSACG.
   (e) If this SRA is being submitted to terminate a current salary reduction, please list the company name to be terminated and indicate "Terminate Reduction" in the space provided (check box).
   (f) Total the dollar amount for all contributions and enter the total in the box provided.
5. Provide agent name and telephone number, if applicable.
6. Sign and date the agreement. Please provide a telephone number where you can be reached during business hours.
7. Mail the completed original signed agreement to:
   TSA Administration Services, Attn: SRA Processing Department, P.O. Box 4037, Fort Walton Beach, FL 32549
   or fax the completed form to 1-866-908-7582.

The employer, **Crawford County Community Schools, IN**, will apply and remit the salary reduction documented on page 1 of this SRA form to TSA Consulting Group, Inc. the administrator is providing remittance and administration services for voluntary retirement plans.

PRIVACY - The administrator shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the paln.

The administrator shall disclose information described only:
(a) in response to a court order,
(b) for an examination conducted by the commissioner of insurance;
(c) for an IRS audit or investigation;
(d) to or at the request of the insurer or plan sponsor; or
(e) with the written consent of the identified individual or his or her legal representative.

Crawford County Community Schools, IN
Participation Agreement for the Internal Revenue Code Section 457(b) Deferred Compensation Plan