Town of Provincetown - Public Schools, MA
403(b) Salary Reduction & Allocation Agreement

OMNI & TSACG Compliance Services

☐ Check if new participant
☐ Check if change to existing allocations

Catch-up contribution eligibility
☐ I will be age 50 or older this calendar year.
☐ I will have completed 15 years of service with the Employer this calendar year.

Employee Information

Name _____ Telephone # (_____)_____ SSN _____

Mailing Address_____ Date of Hire _____

City_____ State _____ Zip _____ Date of Birth _____ E-mail _____

Employer Name _____ City _____ State _____

Salary Reduction

This agreement shall be legally binding and irrevocable with respect to amounts earned while this agreement is in effect, and any termination of this agreement shall be effective only with respects to amounts not earned at the time of said termination. Subject to the annual contribution limits and other requirements of the 403(b) Plan of the Employer, I authorize the Employer to reduce my cash compensation in exchange for the prompt payment of an equal amount for deposit to a qualified annuity contract or custodial account as a salary reduction contribution under the Plan. The amount of such reduction and payment shall be as follows: $_____ per pay period. **This salary reduction agreement will supersede all previous 403(b) salary reduction elections under the Plan. 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.**

Allocation of Contributions

Please indicate ALL of the annuity contracts or custodial accounts to which salary reduction contributions should be allocated. **Allocations listed below will supersede all previous allocations for salary reduction contributions.** Allocations will be satisfied in the order listed below with any excess remaining allocated to the last account listed. Allocations may only be made to an annuity contract or custodial account that is approved for use with the Plan.

Provider and Allocation Information				
Product Provider Name	Address for Premium Remittance	EE or ER Contribution	Policy Number	Amounts
				$
				$
				$
				$
		(Total includes EE salary deferrals and ER contributions)	Total per Pay Period	$

Effective Date and Duration

The Salary Reduction and Allocation Agreement shall take effect:
☐ As soon as permitted under the Plan and as soon as administratively feasible; or
☐ Not before _____ /_____ / 20_____.

This agreement will remain in effect as long as I remain an eligible employee under the Plan, or until I provide the Employer with a written request to end my salary reduction contributions or submit a new Salary Reduction and Allocation Agreement, as permitted under the Plan.

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.

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.

_____ _____ _____
Employee Signature | *Date (mm/dd/yyyy)* | *Employee Name (Please Print)*

_____ _____ _____
Financial Professional Name | *Phone* | *E-mail*

_____ _____
Employer Authorized Signature (if required) | *Date (mm/dd/yyyy)*

ver 12.21.2022