Hesperia Community Schools, MI
Salary Reduction Agreement for 403(b) Annuity Contract or 403(b)(7) Custodial Account

Please Print or Type Legibly

1

Employee Name

Employee Email Address | **Work Location**

Mailing Address

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

***Reductions are not withheld for 10/11 month employees during the summer.**

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	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.**

5

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

COMPANY NAME (For Unused Sick Leave Payout ONLY)	PAYROLL SLOT NUMBER	REQUESTED SALARY REDUCTION AMOUNT (Dollar Amount)	RETIREMENT DATE
		, .	/ /

The ELIGIBLE SRA Reduction amount $, .

Authorized Reduction Amount = the lesser of the Requested SRA amount OR the Eligible amount.

Approved By: _____ (Representative of TSACG)

The amount elected above shall result in a total ANNUAL REDUCTION not to exceed the maximum allowable contribution calculation as stated below. The Employer agrees that it will remit the amount of such reduction and/or change for the 403(b) Tax Sheltered Annuity or 403(b)(7)custodial account offered by the Company (companies) listed above. I realize that if the change results in decrease or elimination of reduction under the 403(b) T.S.A. program, that this reduction or elimination cannot be "made up" in the future unless it falls within the allowable limit for that year.

This Agreement shall be legally binding and irrevocable with respect to amounts earned while the Agreement is in effect, and any termination of this Agreement shall be effective only with respect to amounts not yet earned at the time of said termination. It is provided that this reduction/deduction does not exceed the Employee's statutory limits under Section 402(g) or the limitation of Section 415 of the Internal Revenue Code. This limits the total allowable salary reduction/deduction to all Companies to which salary reduction/deduction contributions can be made. This agreement must also be accompanied by a Product Disclosure form signed by the representative and employee for all original salary reductions established by the Agreement or any changes in investment products relating to this Agreement.

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.

The Employee is responsible for the accuracy of the excludable amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary reduction/deduction in this agreement, or any other violation of the requirement of Section 403(b) could result in additional taxes, interests, and penalties to the Employee.

It is the intent of the parties that the non-forfeitable retirement deferred annuity or custodial contract pursuant to this Agreement shall qualify for the Federal Income Tax benefits provided for in Section 403(b) of the Internal Revenue Code. **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.

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_____
AGENT/REPRESENTATIVE (IF APPLICABLE)-PRINT NAME

_____
AGENT PHONE

_____
EMPLOYER ACCEPTANCE OF AGREEMENT/CONTRACT

7

_____
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.

8

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 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. Complete this section for unused sick leave payout **ONLY**.
6. Provide agent name and telephone number, if applicable.
7. Sign and date the agreement. Please provide a telephone number where you can be reached during business hours.
8. 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 or e-mail to sraprocessing@tsacg.com.

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