Lakeview Public Schools, MI
Payroll Reduction Authorization for ROTH 403(b) Annuity Contract or Custodial Account

Name of Company

Employee Name	Employee ID
Work Location	Position

☐ Original Agreement

With respect to services rendered by the employee hereafter, the Employer and the employee hereby agree the Employee's compensation for such services shall be reduced by:

☐ Equal amounts of $_____ per pay period beginning the _____, 20_____ pay period. The amount elected above shall result in a total ANNUAL DEDUCTION not to exceed the maximum allowable contribution calculation. The Employer agrees that it will remit the amount of such deduction for the ROTH 403(b) annuity or custodial account offered by the Company listed above.

☐ Amendment Agreement - Type of Change Desired

☐ Increase from $_____ per pay period to $_____ beginning the _____, 20_____ pay period.

☐ Decrease from $_____ per pay period to $_____ beginning the _____, 20_____ pay period.

☐ For TERMINAL LEAVE PAYOUT, deduct $ _____ or Maximum amount possible up to $ _____ after payment of 401(a) Employer Contribution.

Suspend--Name of Company _____

Effective Date of Change or Suspension:_____, 20_____

I have read the above and understand the proposed change. I hereby request that such change be effected. I realize that if the change results in decrease or elimination of deduction under the ROTH 403(b) T.S.A. program, that this deduction or elimination cannot be "made up" in the future unless it falls within the guidelines established by the Internal Revenue Code of 1986, as amended.

NO-LOAD ROTH INVESTMENT OPTIONS ONLY:

I acknowledge receipt of the appropriate disclosure materials (prospectus, etc.), and I am aware of the Maximum Allowable contribution limits for the current calendar year. (Product Disclosure Form not required).

_____
Employee's Initials

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. It is understood that the amount specified will be forwarded to the Company listed above, provided that the Employee has sufficient earnings during the immediately preceding pay period to accommodate the requested reduction. In the event that the calculations provided by the District are lower than the calculations provided by the company / representative, the District's calculation shall prevail.

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.

Lakeview Public Schools, MI

Effective Date of this Agreement _____, 20_____.

_____ _____
AGENT / REPRESENTATIVE NAME AGENT / REPRESENTATIVE PHONE NUMBER

_____ _____
EMPLOYEE EMPLOYER

DATED _____, 20_____ DATED _____, 20_____

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