

Magnolia Board of Education, NJ

Salary Deduction Agreement for ROTH 403(b) Annuity Contract or Custodial Account

Please Print or Type Legibly

Page 1 of 2

1 Employee Name _____

Employee Email Address _____ Work Location _____

Mailing Address _____

Number of Payrolls Per Year: _____

*Deductions are not withheld for more than two (2) payrolls per month.

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| | | | | | | | |
|---------------------------------|--|--|--|--|--|--|--|
| | | | | | | | |
| Employee I.D. Number | | | | | | | |
| | | | | | | | |
| Employee Social Security Number | | | | | | | |

3 Original Agreement or Amendment to a Previous Agreement

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

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

| COMPANY NAME | PAYROLL SLOT NUMBER (if applicable) | SALARY DEDUCTION AMOUNT (Dollar Amount) | EFFECTIVE PAYROLL DATE (New account or amendment - MM/DD/YY) | Terminate Reduction |
|--------------|----------------------------------------|--------------------------------------------|-----------------------------------------------------------------|--------------------------|
| | | , . | / / | <input type="checkbox"/> |
| | | , . | / / | <input type="checkbox"/> |
| | | , . | / / | <input type="checkbox"/> |

The total amount of contributions to all providers _____ for each pay period.

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

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 deduction/reduction to all Companies to which salary deduction/reduction contributions can be made. It is understood that the amount specified will be forwarded to the Company listed above. 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.

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 Employee is responsible for the accuracy of the excludable amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary deduction/reduction 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 _____

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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.

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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 deduction 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 deduction, please list the company name to be terminated and indicate "Terminate Deduction" 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.