Pen Argyl, Pennsylvania
Payroll Reduction Authorization for 403(b) Annuity Contract or 403(b)(7) Custodial Account

Name of Company

☐ **No Load Account** (No Agent Signature or Product Disclosure Form Required)

☐ **Low Fee Account**

Employee's Name	Social Security Number
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 REDUCTION not to exceed the maximum allowable contribution calculation. The Employer agrees that it will remit the amount of such reduction for the 403(b) Tax Sheltered Annuity or 403(b)(7) 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.

☐ Suspend—Name of Company _____

Effective Date of Change _____, 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 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 limits for that year.

☐ Terminal Pay at Retirement or Termination

☐ One-time reduction from Terminal Pay $_____ Date of Retirement _____
Total from Terminal Pay

The Employee expressly understands and agrees that if the amount requested above is more than the amount due to the Employee (less applicable taxes), no reduction will be made and the entire amount will be paid to the Employee.

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 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 to all Companies to which salary reduction 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 that 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 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 of 1954, as amended. **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.

Effective Date of this Agreement _____, 20 ____.

_____
AGENT / REPRESENTATIVE

Pen Argyl, Pennsylvania

_____
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