Harlingen CISD, TX
Participation Agreement for Internal Revenue Code Section 457(b) Deferred Compensation Program

Name of Company--457(b) Product Provider

Employee 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.

☐ **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 _____ **Effective Date of Suspension**:_____, 20_____
NAME OF COMPANY

The undersigned hereby agrees to the terms and conditions of the **Harlingen CISD, TX** Deferred compensation Plan ("Plan") as such Plan now exists or is hereinafter amended and a copy of the Plan has been made available to them. This election shall continue until the undersigned makes a subsequent election as provided by the Plan. The employer hereby authorizes on the provider company to issue an annuity contract or custodial arrangement for the benefit of the participant without the signature of the employer provided that the owner of the annuity contract or custodial arrangement is designated as the employer's 457 Deferred Compensation Plan.

I (the Employee) understand and agree to the following:

My deferrals cannot begin sooner then the month following Participation Agreement approval. My accumulated deferrals will be held in trust by the **Harlingen CISD, TX** for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the Plan. I realize I may not assign or transfer my rights under the Plan.

I am responsible for the accuracy of the excludable amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary reduction in the agreement, or any other violation of the requirement if IRS Code Section 457 could result in additional taxes, interest, and penalties to the Employee.

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 Employer hereby authorizes on the provider company to issue an annuity contract or custodial arrangement for the benefit of the participant without the signature of the employer provided that the owner of the annuity contract or custodial arrangement is designated as the employer's 457 Deferred Compensation Plan.

Earnings, if any, will be applied to my accumulated deferrals in accordance with the Company and product I have selected. Neither the Employer, nor Trustees, nor agencies of the Employer shall be liable for the performance of the companies or products selected by the Employee. **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.

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.

Harlingen CISD, TX

Effective Date of this Agreement _____, 20_____

_____
. AGENT / REPRESENTATIVE NAME

_____ DATED _____, 20_____
EMPLOYEE NAME

_____ DATED _____, 20_____
EMPLOYER REPRESENTATIVE NAME

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
Phone: 1-888-796-3786 Opt. 5