Northwood Technical College, WI
Participation Agreement for Internal Revenue Code Section 457(b)
Deferred Compensation Program

1. Employee Information

Employee Name	Social Security Number
Work Location	Position

2. Plan Type

☐ **457(b)** ☐ **457(b)Roth**

3. 457(b) Deferred Compensation Reduction/Deduction (Check all that apply)

Part A.

☐ **New Participant** ☐ **Change Account** ☐ **Discontinue Contribution**

Part B.

Authorized Investment Provider Name:_____

Increase from _____% per pay period to _____% beginning the _____, 20_____pay period.

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

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/deduction under the 457(b) Deferred Compensation program, that this reduction/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.

The undersigned hereby agrees to the terms and conditions of the 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 than the month following Participation Agreement approval. My accumulated deferrals will be held in trust by my employer 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 the Agreement. Any overstatement of the amounts excludable as a salary reduction/deduction in the agreement, or any other violation of the requirement of IRS Code Section 457 could result in additional taxes, interest, and penalties to the Employee.

I hereby authorize my Employer to reduce/deduct or suspend any deferrals established by this agreement, if in its opinion, the total annual deferral would exceed the maximum allowable limit in any calendar year. Should my deferral exceed the maximum limit, I authorize my Employer to disallow deferral of the excess and direct these amounts to be refunded to me.

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 company, or my selection and purchase of shares of regulated investment companies.

The employer hereby authorizes 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.

Any change to this Agreement must be in writing to the Employer and becomes effective upon the execution of the 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.

Northwood Technical College, WI

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:

U.S. OMNI & TSACG
Compliance Services
Attn: SRA Processing Dept.
P.O. Box 4037
Fort Walton Beach, FL 32549

Fax: 1-866-908-7582