

403(b) Salary Reduction Agreement

Voorheesville CSD 403(b) Plan

(Employer /Plan Name)

1. EMPLOYEE/PARTICIPANT INFORMATION

First Name:	M.I.	Last Name:
Social Security Number:	Birth Date:	Hire Date:
Address:		
Phone Number:	Email:	Marital Status: Single Married Union Member: YES NO

2. AGREEMENT

The above named Employee elects to become a participant of the Employer's 403(b) Plan and agrees to be bound by all the terms and conditions of the plan. By executing this agreement, Employee authorizes Employer to reduce his or her compensation and have that amount contributed as an elective deferral and/or as a salary reduction contribution to the Roth 403(b) option if permitted in the plan, on his or her behalf into the annuity or custodial accounts as selected by employee. It is intended that the requirements of all applicable state or federal income tax rules and regulations (Applicable Law) will be met. Employee understands and agrees to the following:

- 1) This Salary Reduction Agreement is legally binding and irrevocable with respect to amounts paid or available while this agreement is in effect;
- 2) This Salary Reduction Agreement may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new Salary Reduction Agreement is submitted; and
- 3) This Salary Reduction Agreement may be changed with respect to amounts not yet paid or available in accordance with Employer's administrative procedures.

Employee is responsible for providing the necessary information at the time of initial enrollment and later if there are any changes in any information necessary or advisable for Employer to administer the plan. Employee is responsible for determining that the salary reduction amount does not exceed the limits set forth in applicable law. Furthermore, Employee agrees to indemnify and hold Employer harmless against any and all actions, claims, and demands whatsoever that may arise from the purchase of annuities or custodial accounts. Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein. Employee agrees Employer shall have no liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the annuity and/or custodial account. Nothing herein shall affect the terms of employment between Employer and Employee. This agreement supersedes all prior salary reduction agreements and shall automatically terminate if Employer's employment is terminated.

Employee is responsible for setting up and signing the legal documents to establish an annuity contract or custodial account. However, in certain group annuity contracts, Employer is required to establish the contract.

Employee is responsible for naming a death beneficiary under annuity contracts or custodial accounts. Employee acknowledges that this is normally done at the time the contract or account is established and reviewed periodically.

Employee is responsible for all distributions and any other transactions with Vendor. All rights under contracts or accounts are enforceable solely by Employee, Employee beneficiary, or Employee's authorized representative. Employee must deal directly with Vendor to make loans, transfers, apply for hardship distributions, begin regular distributions, or any other transactions.

3. VOLUNTARY SALARY REDUCTION INFORMATION

- | | |
|---|--------------------------------------|
| I do not wish to participate at this time. | (Complete section 6) |
| Initiate new salary reduction | (Complete Section 4 and 6) |
| Change salary reduction | (Complete Section 4 and 6) |
| Change Investment Service Provider | (Complete Section 4, 5 and 6) |
| Discontinue salary reduction | (Complete Section 5 and 6) |

4. SERVICE PROVIDER AND DEFERRAL ELECTION

1. If initiating a salary reduction agreement for the first time, please provide the service provider name and account #(if known) for your newly established account. Also indicate the amount per pay period you would like withheld from your paycheck
2. If you wish to change the amount withheld from your paycheck, please provide your service provider name and account #(if known) and indicate the old amount that was being withheld from your paycheck and state the new amount you wish to have withheld from your paycheck.
3. If you are changing service providers, please indicate the new service provider name and account #(if known) for your newly established account, also indicate the amount per pay period you would like withheld from your paycheck. Once completed please proceed to section 5 to indicate the old service provider for whom you no longer wish to have contributions sent to, also indicate the per pay amount that is being discontinued for that service provider.

Service Provider Name:	Account # (if known):	Old Amount Per Pay Period \$ amount:	New Amount Per Pay Period \$ amount:

I elect to make catch-up deferrals in the amount of \$ _____.

5. DISCONTINUANCE OF SERVICE PROVIDER AND DEFERRAL ELECTION

1. If you wish to discontinue your contribution to a service provider please indicate the service provider name and account #(if known) as well as the per pay amount you wish to have discontinued. By entering the service provider name and amount below and checking the check box you are confirming that you no longer wish to have contributions sent to that vendor .

Service Provider Name:	Account # (if known):	Old Amount Per Pay Period \$ amount:	Check Box to confirm discontinued deferral

6. SIGNATURES & AUTHORIZATIONS

I certify that I have read this complete agreement and provided the information necessary for Employer to administer the Plan and that my salary reductions will not exceed the elective deferral or contribution limits as determined by Applicable Law. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the annuity or custodial account established by me under the Program are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature

Date

TO BE COMPLETED BY THE EMPLOYER & THIRD PARTY ADMINISTRATOR

Employer hereby agrees to this Salary Reduction Agreement:

Employer Signature

Date

Print Name

Title

Third Party Administrator verifies this Salary Reduction Agreement:

Third Party Administrator Signature

Date

Print Name

Title

Please return this agreement to Benetech, Inc., unless otherwise advised by your Employer:

If you have any questions regarding this agreement please direct to Benetech, Inc.

Benetech, Inc.

1 Dodge Street | Wynantskill, NY 12198
Phone: (518) 880-4067 | Fax: (518) 880-4068

7. ACKNOWLEDGEMENT/APPOINTMENT OF FINANCIAL ADVISOR/SALES AGENT (IF APPLICABLE)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. A calculation of maximum allowance will be provided annually for Employee contributing more than \$16,500 (\$22,000 if over 50) or utilizing the “catch-up provisions”. Furthermore, my employer (name) _____ agrees to indemnify and hold harmless the Employer, and individual member of the governing board and the Employee participating in the 403(b) Program against any claims based on an error in the MAC I provided, except where the error is based upon erroneous information provided by Employer or Employee. Additionally, I will notify Benetech, Inc. regarding any distributions or loans to participants.

Advisor/Sales Agent Name: please print

Phone

Address

Advisor/Sales Agent Signature

Date

**Please return this agreement to Benetech, Inc., unless otherwise advised by your Employer:
If you have any questions regarding this agreement please direct to Benetech, Inc.**

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