



SRA – SALARY REDUCTION AGREEMENT 457(b) (DCP) Plan

This Agreement must be signed by the Employee and received by the Plan Administrator. If you participate in multiple 457(b) Defined Contribution Plan (DCP) accounts, all salary reductions must be on one SRA form. This Agreement is not effective until approved. This Agreement is irrevocable by the Employee as to any salary or amounts paid, but may be terminated or changed as to salary not yet paid. Compensation to be paid to this Employee shall be reduced by the sum indicated below per pay period starting with the compensation to be paid on the date requested below, or the first available payroll period after all requirements are satisfied.

THIS AGREEMENT SUPERCEDES AND REPLACES ALL PRIOR DCP/457(b) SALARY REDUCTION AGREEMENTS – INCLUDING THE AMOUNT(S), PROVIDER(S), AND EFFECTIVE DATE(S).

BLACK INK ONLY Check here if you are contributing to another retirement plan:

EMPLOYER NAME:			
Employee Name		Social Security Number	Date of Birth
Phone (Day)	Phone (Home)	Mailing Address	City, State, Zip
Email Address		Salary Reductions: <input type="checkbox"/> 10-months <input type="checkbox"/> 11-months <input type="checkbox"/> 12-months	<input type="checkbox"/> Classified <input type="checkbox"/> Certificated

DCP/457(b) PLAN

- This is to **Initiate** a New 457(b) Salary Reduction Agreement (**Check only if not currently participating**)
- This is to **Change** the **Amount** of my currently existing 457(b) Salary Reduction Agreement
- This is to **Change** my **Company/Provider**
- This is to **Terminate** my 457(b) Salary Reduction Agreement (Indicate below the Effective Date & Company/Provider Name)

Monthly Amount \$ _____ Effective with my payroll date (mm/dd/yyyy) _____, 20____

The Employer in accordance with the Employer's 457(b) Plan shall transmit the above in the following manner:

\$ _____ To: _____ Date Acct Established: _____

\$ _____ To: _____ Date Acct Established: _____

FOR ENVOY USE ONLY
Deduction Code: _____
Deduction Code: _____

EMPLOYEE ACKNOWLEDGES that Employee has read, understands, and agrees to the terms and conditions set forth on the reverse side of this form. Employee further understands that a termination of salary reduction contributions to a provider that has not complied with or maintained registration in IN WITNESS WHEREOF, this Agreement has been executed by and on behalf of the parties hereto and the Employee has read and understands the terms and conditions listed on the reverse side of this form.

Employee Signature: _____ **Date:** _____

ADVISOR/BROKER INFORMATION:

Agent/Broker Name: _____ **Phone:** _____ **Email:** _____