

403(b) Salary Reduction Agreement

First Financial Administration, Inc.



EMPLOYEE INFORMATION			
FIRST NAME	LAST NAME	TYPE OF EMPLOYER	STATUS
ADDRESS (PO Box unacceptable)			
DOB	EMPLOYEE EMAIL ADDRESS	PHONE	HOME PHONE
EMPLOYEE ID	ACCOUNT #	PERIODICITY	<input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Other

DEDUCTION 1		
<input type="checkbox"/> NEW/RESUME	<input type="checkbox"/> 403(b)	PROVIDER'S COMPANY NAME
<input type="checkbox"/> CHANGE EXISTING	<input type="checkbox"/> Roth 403(b)	ACCOUNT # (REQUIRED FOR ROTH CONTRIBUTIONS)
<input type="checkbox"/> STOP CONTRIBUTION		
<input type="checkbox"/> HARDSHIP REQUEST - STOP DEDUCTION	START DATE	REASON FOR REQUEST
MONTHLY REDUCTION AMOUNT \$		

DEDUCTION 2		
<input type="checkbox"/> NEW/RESUME	<input type="checkbox"/> 403(b)	PROVIDER'S COMPANY NAME
<input type="checkbox"/> CHANGE EXISTING	<input type="checkbox"/> Roth 403(b)	ACCOUNT # (REQUIRED FOR ROTH CONTRIBUTIONS)
<input type="checkbox"/> STOP CONTRIBUTION		
<input type="checkbox"/> HARDSHIP REQUEST - STOP DEDUCTION	START DATE	REASON FOR REQUEST
MONTHLY REDUCTION AMOUNT \$		

DEDUCTION 3		
<input type="checkbox"/> NEW/RESUME	<input type="checkbox"/> 403(b)	PROVIDER'S COMPANY NAME
<input type="checkbox"/> CHANGE EXISTING	<input type="checkbox"/> Roth 403(b)	ACCOUNT # (REQUIRED FOR ROTH CONTRIBUTIONS)
<input type="checkbox"/> STOP CONTRIBUTION		
<input type="checkbox"/> HARDSHIP REQUEST - STOP DEDUCTION	START DATE	REASON FOR REQUEST
MONTHLY REDUCTION AMOUNT \$		

- Qualifications**
- Retirement
 - Disability
 - Severance from employment
 - Death
 - HARDSHIP AT AGE 50 1/2

I understand and agree to the following:

- This Salary Reduction Agreement is an agreement between me and my employer to reduce my salary.
- This agreement is voluntary, binding, and enforceable under applicable law or terms of my employment.
- This form needs to be completed for each pay period.
- I have read and understand the information provided to me.
- THIS AGREEMENT SUPERSEDES ALL PREVIOUS AGREEMENTS.

IF MY EMPLOYMENT IS TERMINATED, THIS AGREEMENT SHALL BE TERMINATED AND I SHALL BE RESPONSIBLE FOR PAYING THE BALANCE OF MY CONTRIBUTIONS TO THE PLAN.

CONTINUED

SIGNATURE	
EMPLOYEE SIGNATURE	DATE
AGENT NAME	DATE
AGENT SIGNATURE	DATE

