Commonwealth of Massachusetts **SALARY REDUCTION AGREEMENT FOR 403(b) Plan**

College Name or Department:

Part 1 Employee Information: Name: _____Employee ID _____

By THIS AGREEMENT, made between _____ (the Employee) and the Commonwealth of Massachusetts (the Employer), the parties hereto agree as follows:

Effective for amounts paid on or after _____, 20___, which date is subsequent to the execution of this Agreement, the Employee's salary (as defined by the Plan) will be reduced by the amount indicated below. At the same time, the Employer will contribute a corresponding amount to the Employee's annuity contracts or custodial accounts which the Employee will allocate among the funding vehicles approved by the Commonwealth.

This agreement shall be legally binding and irrevocable for both the Employer and the Employee while employment continues, except that the Agreement will be suspended for six months following distribution to the Employee by the Plan of a Financial Hardship Withdrawal. However, either party may terminate this Agreement by providing reasonable notice so that this Agreement will not apply to salary subsequently paid as of the pay period next following the notice of termination.

Part 2 Contribution Information: (Select all that apply): Effective Date: Pay period beginning _____

- ❑ Initiate new salary reduction: Deduct the amount of $_____ per pay period or _____% of Salary.
- ❑ Change salary reduction: This is notification to change the amount of my 403(b) salary reductions from $_____ per pay to $_____ per pay or _____% of Salary
- ❑ Change or Discontinue Service Provider: From _____ to _____
- ❑ Implement Age 50 catch-up: Date of birth _____

The IRS requires coordination of contributions to this plan with contributions to plans of other employers in which you may participate. Please respond to the two questions below.

1. I make voluntary, tax-deferred contributions to a 403(b) and/or 401(k) plan of another employer. ☐ Yes ☐ No
2. I own more than 50% of an outside business. ☐ Yes ☐ No

Part 3 Authorized Service Providers: (Check One)

☐ **Fidelity (TSHFGA)** ☐ **TIAA-CREF (TSHTIA)** ☐ **VALIC (TSHVMF)**

Part 4 Employee Signature:

I certify that I have read and understand this complete agreement and that my salary reductions do not exceed contribution limits as determined by applicable law.

☐ I have enrolled on-line with chosen provider and establish my account.

☐ I have been employed at a campus of the University of Massachusetts within the past year.

Employee Signature: _____ Date: _____

Part 5 Employer Signature: Employer hereby agrees to this salary Reduction Agreement.

Employer Signature: _____ Date: _____

Title: _____

Part 6 Termination of Agreement: This agreement will be terminated as of _____

Employee Signature: _____Date: _____

Employer Signature: _____ Date: _____

Form updated 8/2016