

College Name or Department: **BRISTOL COMMUNITY COLLEGE**

Part 1 Employee Information: Name: _____ Employee ID _____

Address: _____

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 will be reduced by the amount indicated below. At the same time, the Employer will contribute a corresponding amount to the Employee's annuity contract(s) (or custodial accounts, if applicable) which the Employee will allocate among the funding vehicles approved by the Institution.

This agreement shall be legally binding and irrevocable for both the Employer and the Employee while employment continues. However, either party may terminate or otherwise modify this Agreement as of the end of any pay period by giving at least fifteen (15) days written notice so that this Agreement will not apply to salary subsequently paid.

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

- Initiate new salary reduction: deduct the amount of \$_____ per pay period for \$_____ per year
- Change salary reduction This is notification to change the amount of my 403(b) salary reductions from \$_____ per pay to \$_____ per pay for total \$_____ per year
- 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 employer outside this institution/department. ___ Yes ___ No

Part 3 Authorized Service Providers:

___ VALIC(TSHVAL) ___ AXA-Equitable(TSHEQU) ___ Fidelity(TSHFYI) ___ ING(TSHALA)
 \$ _____ \$ _____ \$ _____ \$ _____

___ Lincoln Alliance(TSHLIA) ___ MetLife MFSP(TSHMFP) ___ TIAA-CREF(TSHTIC)

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 or have forwarded enrollment forms to the provider to establish my account.

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: _____