JHS 403(b) Salary Reduction Agreement Form

FBMC Benefits Management, Inc.
(305)-585-6512
FAX: (305)-585-0042

Instructions: Use this form if you wish to direct your Employer to reduce your compensation and direct this compensation to become an elective deferral under your Employer's 403(b) Program, or if you want to change your existing Salary Reduction Agreement. This Agreement is between you and your Employer. Unless otherwise instructed, please complete this form and FAX to Onsite FBMC Service Center 305-585-0042. Please retain a copy of this agreement for your records.

This form must be processed by FBMC, the 403(b) Administrator.

When completing this form, please type or print clearly in all **CAPITAL LETTERS** using black ink.

Participant Information

Name (First, Middle Initial, Last)			
Social Security Number		Date of Birth (MM-DD-YYYY)	
Street Address			Apartment
City	State	Zip Code/Postal Code	
Work Telephone	Extension	Home Telephone	

Agreement

This Agreement is made between the participant named above ("Participant") and Jackson Health System.

Please complete all steps:

STEP 1	STEP 2	STEP 3		
☐ Current Provider ☐ New Provider	☐ Fidelity ☐ Lincoln ☐ VALIC ☐ VOYA ☐ Metlife/Travelers (changes only)	☐ Pre-Tax Dollar Amount $_____ Effective date ___/____/_____	or Percentage _____% Effective date ___/____/_____	☐ Roth Dollar Amount $_____ Effective date ___/____/_____

☐ **Special Payout $** _____ **DCU:** ☐ **Yes** ☐ **No**

A. I hereby agree to reduce my eligible compensation (i.e., wages or salary) by the amount and effective date listed above. My Employer agrees to contribute this amount on my behalf to the investment options I have selected under my 403(b) Account.

B. I understand that I may change the amount of my salary reduction at any time, as permitted under the terms of my Employer's 403(b) Program, by submitting this form with the change to my 403(b) Administrator 30 days prior to the date that I wish the change to take effect.

C. I further understand that I may terminate this Agreement at any time by submitting this form with $0 to my 403(b) Administrator 30 days prior to the date I wish this Agreement to be terminated.

D. This Agreement may not permit an aggregate amount of salary reduction contributions under the plan, which when added to elective deferrals made on my behalf to certain other plans, such as a 403(b) arrangement, a SIMPLE plan, or a 401(k) plan, exceeds the limits as may be in effect for the year under (i) Code Section 402(g)(1) or 402(g)(7), if applicable, and (ii) Code Section 414(v), if applicable. I understand that I am responsible for determining that the amount of my salary reduction listed above in this section does not exceed any applicable limit. I also understand that my Employer will provide to me upon my request any available information from the Employer's records that is necessary to enable me to make these determinations.

E. I understand that if I am age 50 or older and my Employer transmits salary reduction contributions on my behalf in excess of otherwise applicable limits, such contributions shall be treated as Catch-Up Contributions. You may wish to contact your tax advisor if you need assistance to determine your maximum allowable contribution (MAC).

Signatures

The Participant agrees to this Salary Reduction Agreement

Signature of Participant	Date
Signature of Agent	Date
Print Agent Name	Date