

SALARY REDUCTION AGREEMENT 403(b) RETIREMENT PLAN

1. EMPLOYER/PLAN NAME

Employer/Plan Name VF6904 Learning Disabilities Association Inc.

2. TYPE OF REQUEST

☐ Initial Salary Reduction Contribution ☐ Change to Existing Salary Reduction Contribution

3. PARTICIPANT INFORMATION

Name (last, first, middle initial) _____ SSN/Employee ID _____

Date of Birth (mm/dd/yyyy) _____ Date of Hire (mm/dd/yyyy) _____

Home Phone _____ Work Phone (include extension) _____ Mobile Phone _____

4. SALARY REDUCTION ELECTION

I hereby authorize my employer to reduce my compensation (as defined in the 403(b) plan (the Plan)) by _____ % or \$ _____ and to apply such amount each pay period toward the purchase of the funding vehicle(s) offered by providers approved under the Plan, an authorized provider under the Plan. I understand that this election applies only to compensation paid or made available after the date that this Agreement is signed. I further understand that this Agreement is irrevocable with respect to compensation paid and shall supersede any prior Agreement between my employer and me under the Plan.

☐ Elective Deferrals

☐ Pretax¹ _____ % or \$ _____ (per pay period)

☐ Roth¹ _____ % or \$ _____ (per pay period)

☐ 15 Years of Service Catch Up^{1,2} _____ % or \$ _____ (per pay period)

☐ Age Based Catch Up^{1,2}

☐ Age 50-59, 64+ _____ % or \$ _____ (per pay period)

☐ Age 60-63 _____ % or \$ _____ (per pay period)

¹Roth Contributions, 15 Years of Service Catch Up and Age Based Catch Up are available only if permitted under the Plan document.

²The pre-tax/Roth allocation selected under "Elective Deferrals" will be applied to any catch up contribution unless the Plan provides otherwise.

I direct my employer to remit contributions pursuant to this Agreement to the following Provider approved under the Plan:

☐ _____

I understand that it is my responsibility to establish an account with my selected Provider by completing the required enrollment forms prior to submitting this request.

- If an employee selects the 15 Years of Service Catch Up, he must have at least 15 years of service with the current employer sponsoring the Plan and that employer must be an educational organization, hospital, home health service agency, health and welfare agency, church, or convention or association of churches. A calculation is needed to determine the amount available that an eligible employee can contribute under the 15 Years of Service Catch Up in a tax year. Contact your local Voya Financial representative for additional information.
- If an employee is eligible for both the 15 Years of Service Catch Up and the Age Based Catch Up in the same tax year, he must first contribute the full amount available under the 15 Years of Service Catch Up before contributing under the Age Based Catch Up in that tax year.

PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR EMPLOYER. KEEP A COPY FOR YOUR RECORDS.

Note that it may take several payroll cycles for your payroll office to process this agreement.

5. EFFECTIVE DATE *(Effective Date must be after the date this Agreement is signed by the Employee and Employer and applies only to compensation paid or made available after that date.)*

Pay Period Starting Date *(mm/dd/yyyy)* _____

6. PARTICIPANT AND EMPLOYER SIGNATURES

This Agreement is made between the Participant (as indicated below) and the Employer in conjunction with the Plan. The election(s) indicated above will remain effective until later revoked by the Participant, the terms of the Plan require a suspension of contributions, or a subsequent Agreement is entered into between the Participant and the Employer.

This Salary Reduction Agreement replaces and cancels all previous agreements on file.

In signing this form, the Participant acknowledges that the maximum allowable contribution each year to the Plan cannot exceed the limits set forth in Sections 402(g), 415 and 414(v) of the Internal Revenue Code of 1986, as amended, and that the information provided on this form is complete and accurate, including but not limited to the Participant's age and years of service with the Employer as of the end of this tax year.

Employer/Plan Name _____

Authorized Signer Name _____

Authorized Signature _____ Date *(mm/dd/yyyy)* _____

Title _____

Participant Signature _____ Date *(mm/dd/yyyy)* _____

Signed in City/Town _____ Signed in State _____