403(b)(7) Contribution Form: Salary Reduction Agreement

Plan Name: New Mexico Consortium 403(b) Plan

This is a sample form provided to you. After signing this agreement, send to your plan administrator to keep with your record. Please do not send this form to Vanguard.

I - Plan participant information (required):

Name (First)	(Middle Initial)	(Last)	Social Security Number / Tax ID

Date of Birth (mm/dd/yyyy)	Daytime Telephone Number	E-mail

Street Address	City	State	Zip

Date of Hire:

Note: If you've applied for a SSN or a TIN but haven't received it, enter the date on which you applied in the Social Security Number / Tax ID box above.

II - Reason for salary reduction (required):

☐ New Enrollment ☐ Change ☐ Terminate salary reduction

III - Elective deferral authorization (required):

Please complete this section based on options available to you in your plan. Check with your plan administrator for which options would apply. NOTE: The Employer reserves the right to reduce a participant's salary deferral election if necessary to ensure the plan's compliance with the Internal Revenue Code.

☐ **Waiver**: I have been offered the opportunity to participate in the Plan and to make 403(b) salary deferral contributions and waive my option to participate at this time.

☐ **Regular Compensation** - For deposit into the Plan for my benefit, I request that the below amount be deducted from my pay each pay period. (Choose either Fixed Dollar Amount or Percentage below):

☐ Fixed Dollar Amount (choose all that apply):

- ☐ Before-tax amount: $_____
- ☐ Roth amount: $_____

☐ Percentage – whole % only (choose all that apply):

- ☐ Before-tax amount: _____%
- ☐ Roth amount: _____%

IV - Signature of plan participant or recipient (required):

I understand that this salary reduction agreement shall remain in effect until I revoke or change it in writing.
By signing below, I certify that the information I have provided in the preceding sections above is accurate and complete. I further certify that that the number shown on this application is my correct Social Security Number / Taxpayer Identification Number.

WAIVER: If I have chosen to waive participation, in the above named plan, I hereby acknowledge that I have been offered the opportunity to participate in the Plan and to make salary deferral contributions and I have waived my option to participate at this time. I understand that this election to waive participation will remain in effect until such time as I make another election in writing. I release and hold harmless the Plan Administrator, the Employer and the custodian of the Plan from and against any claims I may have with respect to my election not to contribute to the Plan.

X _____ _____ _____

Plan Participant/Recipient signature | Print name | Date

V - Signature of plan administrator (required):

I certify that the individual referenced in section I – Plan participant information is a Participant under the plan.

X _____ _____ _____

Plan Administrator signature | Print name | Date

Return completed form to your Plan Administrator/TPA for processing and retain a copy for your personal records.