Rowan-Salisbury SCHOOL SYSTEM
Extraordinary Education Every Day

403b/457 SALARY REDUCTION AGREEMENT

First Name Middle Name Last Name	Social Security #	Date of Birth
Home Street Address City	Telephone #	Cell Phone #
State Zip Code Email Address	Date of Hire	School District Phone #
Effective Date of Change Specified Date _____/_____/_____ or Earliest Pay Cycle Possible	#deductions per year 9 10 12 other_____	School Location Phone #

Vendor Name	Product Name	Product Type 403B Roth 403B 457	Deduction Amount	Action Desired N-New S-Stop E-Existing I-Increase D-Decrease
1.				CIRCLE ONE N S E I D Amend From $_____To $_____
2.				CIRCLE ONE N S E I D Amend From $_____To $_____
3.				CIRCLE ONE N S E I D Amend From $_____To $_____
4.				CIRCLE ONE N S E I D Amend From $_____To $_____

Vendor/product/product type/deduction amount and action desired **MUST** be completed for each Plan deduction that you wish to have remitted to a vendor. Information must be complete. **INCOMPLETE INFORMATION WILL BE RETURNED TO THE SALES REPRESENTATIVE FOR COMPLETION BEFORE MAKING CHANGE.**

TOTAL DEDUCTIONS $_____

403b/457
SALARY
REDUCTION AGREEMENT

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I understand and Agree to the Following:

1. This agreement cancels all previous agreements and will remain in force, as long as I am an eligible employee, until modified or cancelled by a new salary reduction agreement (SRA) being completed and submitted by payroll deadline.
2. I authorize the employer to reduce or suspend any contributions established by this agreement, if in its opinion: the total annual contributions would exceed my Maximum Allowable Contribution in any calendar year, or as otherwise provided by the Plan.
3. I authorize my Employer to obtain information from the issuers of the annuity contracts and custodians of the custodial accounts for purposes relating to the maintenance or administration of the Plans.
4. I acknowledge that my Employer has made no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account here within. I agree my Employer shall have no liability whatsoever for any and all losses suffered by me with regard to my selection of the annuity and/or custodial account, its terms, the selection of the insurance company, custodian, or regulated investment company, the financial condition, operation of or benefits provided by said insurance company, custodian, or regulated investment company, or my selection and purchase of shares of regulated investment companies.
5. I am permitted to modify the above listed amounts which are remitted to each annuity contract or custodial account, and such modification may only be affected by my completing and forwarding to the payroll office a new Salary Reduction Agreement. Any modification I make may be subject to limitation by rules or regulations of the issuers of the annuity contracts and custodians of the custodial accounts, as well as any IRS and Treasury rules and regulations.
6. The Third Party Plan Administrator for Rowan County Public Schools is TSA Consulting Group, Inc. 28 Ferry Rd SE, Fort Walton Beach, FL 32548. Toll free number is 800-796-3786. Fax number is 866-741-0645. Website address is www.tsacg.com. My employer will forward the deductions listed above to TSA Consulting Group, Inc. TSA Consulting Group will forward the deductions to respective vendors on my behalf in a timely manner pursuant to the procedures established by my employer.

Employee Signature:_____**Date**:_____

TO BE COMPLETED BY SALES REPRESENTATIVE

I agree to comply with all pertinent written directives regarding the allocation requests of Employees.

Sales Representative Name_____ **Date**:_____
Signature:_____ Phone:_____
Representatives Mailing Address_____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

Employer Confirmation Signature_____Date:_____