SRA – SALARY REDUCTION AGREEMENT
457(b) (DCP) Plan

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866.873.4240 ♦ Fax 863.688.4466 ♦ www.midamerica.biz

This Agreement must be signed by the Employee and received by the Plan Administrator. If you participate in multiple 457(b) Defined Contribution Plan (DCP) accounts, all salary reductions must be on one SRA form. This Agreement is not effective until approved. This Agreement is irrevocable by the Employee as to any salary or amounts paid, but may be terminated or changed as to salary not yet paid. Compensation to be paid to this Employee shall be reduced by the sum indicated below per pay period starting with the compensation to be paid on the date requested below, or the first available payroll period after all requirements are satisfied.

Please note that the contribution amount may not exceed the maximum allowable contribution limits as adjusted annually by the Internal Revenue Service

THIS AGREEMENT SUPERCEDES AND REPLACES ALL PRIOR DCP/457(b) SALARY REDUCTION AGREEMENTS – INCLUDING THE AMOUNT(S), PROVIDER(S), AND EFFECTIVE DATE(S).

EMPLOYER NAME:				
Employee Name		Social Security Number	Date of Birth	Date of Hire
Phone (Day)	Phone (Home)	Mailing Address		City, State, Zip
Email Address		# of Salary Reductions: ☐ bi-weekly ☐ 10-months ☐ 11-months ☐ 12-months		☐ Classified ☐ Certificated

DCP/457(b) PLAN

- ☐ This is to **Initiate** a New 457(b) Salary Reduction Agreement **(Check only if not currently participating)**
- ☐ This is to **Change** the **Amount** of my currently existing 457(b) Salary Reduction Agreement
- ☐ This is to **Change** my **Company/Provider**
- ☐ This is to **Terminate** my 457(b) Salary Reduction Agreement (Indicate below the Effective Date & Company/Provider Name)

Monthly Amount $ ________________ **Effective** with my payroll date (mm/dd/yyyy) _______________, 20__________

The Employer in accordance with the Employer's 457(b) Plan shall transmit the above in the following manner:

Company/Provider Name:

$______________ To: ____ Account # ________________________________

$______________ To: ____ Account # ________________________________

$______________ To: ____ Account # ________________________________

After the initial SRA is submitted and approved by MidAmerica, subsequent changes can be made online at: https://fe2.midamerica.biz/login.aspx.

EMPLOYEE ACKNOWLEDGES that Employee has read, understands, and agrees to the terms and conditions set forth on the reverse side of this form. Employee further understands that a termination of salary reduction contributions to a provider that has not complied with or maintained registration in IN WITNESS WHEREOF, this Agreement has been executed by and on behalf of the parties hereto and the Employee has read and understands the terms and conditions listed on the reverse side of this form.

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Signature of Employee **Date (Please Note: Above date must be within last 90 days to be valid)**

ADVISOR/BROKER INFORMATION:

Agent/Broker Name: __________________________ **Phone:** _________________ **Email:** ________________________________