Salary Deferral Agreement

Check one: ☒ **403(b) Plan** ☐ **457 Plan**

Company Name: AXA EQUITABLE Group # Somerset ISD

Participant Information

Last Name | First Name | MI

Social Security Number

Address - Number & Street

E-Mail Address

City | State | Zip

Date of Birth ☐ Female ☐ Male ☐ Married ☐ Unmarried

Home Phone Work Phone

Salary Deferral Agreement

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, suspended, or the employee ceases to be an eligible employee. This Agreement supercedes all previous agreements.

I understand that I may change the percentage of compensation or dollar amount contributed to the Plan only when and as allowed under the terms of the Plan. I also understand that it is my responsibility to comply with the Internal Revenue Code (the "Coode") deferral limits.

Payroll Information

Specify one of the following:

☐ New Enrollment ☐ Restart ☐ Increase Payroll Deductions ☐ Deceased Payroll Deduction ☐ Stop Deductions

Specify the following:

Before Tax – The total amount that you may contribute to all plans each year is 1% - 100% OR $1.00 - $17,000.00 of your annual compensation, whichever is less. The amount that you may contribute is not to exceed the annual maximum contribution allowable under Internal Revenue Code and applicable regulations and/or the provision of your Plan.

☐ __________% **OR** $__________ (do not complete both) (per pay period) of my compensation as before-tax contributions. I understand that these contributions will be withheld from my paycheck and contributed by the employer to the Plan on my behalf of allocation to my before-tax

☐ I hereby elect not to contribution before-tax dollars to the retirement Plan and thereby do not authorize any deduction of before –tax dollars from my paycheck. Any prior payroll withholding authorization to withhold before-tax dollars is hereby cancelled.

Catch-Up Note: If you are making the maximum contribution allowable and are eligible to make additional contributions, please use the "Application for Catch-Up Contributions."

Multiple Provider – Specify provider name(s) and percentage(s) or dollar amount(s) you wish to allocate per pay period.

PROVIDER NAME	% or $ PER PAY PERIOD
1. AXA EQUITABLE	________% or $__________
2. ____________________	________% or $__________
3. ____________________	________% or $__________

Required Signature(s) – I have completed, understand and agree to the terms of this Agreement.

Participant' Signature Date

Authorized Plan Administrator Signature Date

Participant forward to Plan Administrator