Participant Record/Contribution Change Form

Group Number:	Social Security Number:		
GENERAL INFORMATION (Please print or type) Plan Name:			
Employee Name: ☐**Change** ☐ Mr. ☐Mrs. ☐Ms. ☐Miss	Last:	First:	M.I.:
Address: ☐**Change**			
City:		State:	Zip:
Date of Birth:	Date of Hire:	Date of Eligibility:	Date of Rehire: (if applicable)

Please refer to the Plan, the summary plan description or contact your Plan Administrator for information on the options available under the Plan.

CONTRIBUTIONS

A. ☐ **Elective Deferrals** - I elect to contribute $_____ of my compensation each payroll period on a before-tax basis. (Must be a flat amount)

B. ☐ I wish to discontinue my contributions effective _____.

C. ☐ I wish to not participate in elective deferrals effective _____.

SALARY REDUCTION AGREEMENT

If elected above, by execution of the Participant Record/Contribution Change Form, I authorize my Employer to make contributions to the Plan by reducing my compensation as elected. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 401(k) contributions to ensure the Plan satisfies the requirements of Section 401(k) of the Internal Revenue Code.

SIGNATURES

I acknowledge that I have read and understand the state-specific Fraud Warning Statement, or the NAIC Model Fraud Statement,as applicable.

_____ _____

Employee Signature Date

This Document has been received and accepted by the Plan Administrator.

_____ _____

Plan Administrator Signature Date

To be retained by the Plan Administrator