457(b) DEFERRED COMPENSATION PLAN ENROLLMENT FORM

<<Employer Name>>

SECTION – A

Employee Full Name: ______________________ Social Security #: ______________

Address: ______________________ City: ____________ State: _____ Zip: ________

Date of Birth: ____________ Home Phone: ______________ Work Phone: ______________

Gross Mo. Salary: ______________ Work Site: ______________________

Effective Date of Change: ____/____/______ ☐ 10 Pay ☐ 11 Pay ☐ 12 Pay ☐ Other: ______

SECTION – B

CHECK ALL THAT APPLY: ☐ Increase in Contribution Amount ☐ Decrease in Contribution Amount

☐ New Contributions ☐ Change in Beneficiary ☐ Stop 457(b) Contributions

SECTION – C

COMPANY TO RECEIVE 457(b) CONTRIBUTIONS

The TDS Group – 457(b) Plan $__________ Per Pay Period

SECTION – D

Primary Beneficiary:

Name: ______________________ Relationship: ______________ %: ________

Name: ______________________ Relationship: ______________ %: ________

Contingent Beneficiary:

Name: ______________________ Relationship: ______________ %: ________

Name: ______________________ Relationship: ______________ %: ________

I hereby agree to the terms of the Plan Agreement.

I hereby authorize my employer to reduce my salary by the amount listed in *Section C* of this form beginning on the Effective Date of Change, and to transmit the funds of such salary reduction to the company indicated above for the purpose of participating in a 457(b) Deferred Compensation Plan.

I understand this agreement will remain in effect until I submit a timely termination of authorization or employment.

The employer and employee are the sole participants in this 457(b) Deferred Compensation Plan.

______________________________ ______________
Employee's Signature Date

______________________________ ______________
District Authorized Signature Date

______________________________ ______________
Representative's Name (Please Print) Representative Phone