

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