The School Board of Broward County, Florida
457(b) Salary Reduction & Allocation Agreement

☐ Check if new participant
☐ Check if change to existing allocations

Catch-up contribution eligibility
☐ I will be age 50 or older this calendar year.
☐ I will be within 3 years of normal retirement age this calendar year.

Employee Information

Name _____ Telephone # (_____)_____ SSN _____

Mailing Address_____ Date of Hire _____

City_____ State _____ Zip _____ Date of Birth _____ E-mail _____

Employer Name _____ City _____ State _____

Salary Reduction

Subject to the annual contribution limits and other requirements of the 457(b) Plan of the Employer, I authorize the Employer to reduce my cash compensation in exchange for the prompt payment of an equal amount for deposit to a qualified annuity contract or custodial account as a salary reduction contribution under the Plan. The amount of such reduction and payment shall be as follows: $_____ or _____% per pay period. **(PART-TIME EMPLOYEES MAY ONLY USE THE PERCENTAGE REDUCTION)**

This salary reduction agreement will supercede all previous 457(b) participation agreement elections under the Plan.

Allocation of Contributions

My defferals cannot begin sooner than the month following participation agreement approval. My accumulated deferrals will be held in trust by **The School Board of Broward County, FL** for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the Plan. I realize I may not assign or transfer my rights under the Plan. Please indicate ALL of the annuity contracts or custodial accounts to which salary reduction contributions should be allocated. **Allocations listed below will supersede all previous allocations for salary reduction contributions.** Allocations will be satisfied in the order listed below with any excess remaining allocated to the last account listed. Allocations may only be made to an annuity contract or custodial account that is approved for use with the Plan.

Provider and Allocation Information

Product Provider Name	Address for Premium Remittance	EE or ER Contribution	Policy Number	Amounts
				$
				$
				$
				$
		(Total includes EE salary deferrals and ER contributions)	Total per Pay Period	$

Effective Date and Duration

The Salary Reduction and Allocation Agreement shall take effect:
☐ As soon as permitted under the Plan and as soon as administratively feasible; or
☐ Not before _____ /_____ / 20_____.

This agreement will remain in effect as long as I remain an eligible employee under the Plan, or until I provide the Employer with a written request to end my salary reduction contributions or submit a new Salary Reduction and Allocation Agreement, as permitted under the Plan.

Designation of Beneficiary

The beneficiary for each annuity contract or certified account to which contributions are allocated shall be determined in accordance with the terms of that specific contract or account.

Release of Liability

The Employee agrees that the Employer and its agents shall have no liability whatsoever for any and all losses suffered by me with regard to my selection of the annuity and/or custodial account, its terms, the selection of the insurance company, custodian, or regulated investment company, the financial condition, operation of or benefits provided by said insurance company, custodian, or regulated investment company, or my selection and purchase of shares of regulated investment companies.

The employer hereby authorizes on the provider company to issue an annuity contract or custodial arrangement for the benefit of the participant without the signature of the employer provided that the owner of the annuity contract or custodial arrangement is designated as the employer's 457(b) Deferred Compensation Plan.

_____ _____ _____
Employee Signature | *Date (mm/dd/yyyy)* | *Employee Name (Please Print)*

_____ _____ _____
Financial Professional Name | *Phone* | *E-mail*

_____ _____
Employer Authorized Signature (if required) | *Date (mm/dd/yyyy)*