Commonwealth of Massachusetts
SALARY REDUCTION AGREEMENT FOR 403(b) PLAN

EMPLOYEE INFORMATION	
Name	Employee ID
Institution or Department	

By THIS AGREEMENT, made between _____ (the Employee) and the Commonwealth of Massachusetts (the Employer), the parties hereto agree as follows:

Effective for amounts paid on or after _____, 20___, which date is subsequent to the execution of this Agreement, the Employee's salary will be reduced by the amount indicated below. At the same time, the Employer will send that amount to the Employee's annuity contracts or custodial accounts.

This Agreement shall be legally binding and irrevocable for both the Employer and the Employee while employment continues, except that the Agreement will be suspended for six months following distribution to the Employee by the Plan of a Financial Hardship Withdrawal. However, either party may terminate this Agreement by providing reasonable notice so that this Agreement will not apply to salary subsequently paid as of the pay period next following the notice of termination.

The IRS requires coordination of contributions to this plan with contributions to plans of other employers in which you participate. Please respond to the two questions below.		
I have made voluntary, tax-deferred contributions to a 403(b) and/or 401(k) plan of another employer this year	☐ Yes	☐ No
I own more than 50% of an outside business.	☐ Yes	☐ No

CONTRIBUTION & PROVIDER INFORMATION
Indicate the type and amount of your contribution, and your Provider selection.

One-time Pre- Tax Contribution	One-time After-Tax Contribution
Pre-Tax Contributions: % of salary or $ each pay period	Roth After-Tax Contributions % of salary or $ each pay period
☐ Elect "Age 50 "catch-up My Date of Birth _	☐ Elect "Age 50 "catch-up My Date of Birth
☐ Fidelity (TSHFGA) ☐ TIAA(TSHTIA) ☐ VALIC (TSHVMF)	☐ Fidelity (TSHFGA) ☐ TIAA(TSHTIA) ☐ VALIC (TSHVMF)

Limits Notice: The total dollar amount of contributions for pre-tax, after-tax or a combination of the two in 2024, cannot exceed $23,000 or $30,500 if you are age 50 or older this year**.**

EMPLOYEE SIGNATURE
I certify that I have read and understand this complete agreement, and that my salary reductions do not exceed contribution limits as determined by applicable law.

Check each applicable statement below:
☐ I have opened my Provider Account
☐ I have been employed by the University of Massachusetts within the past year.

Employee Signature	Date

BENEFIT ADMINISTRATOR SECTION	
Name	Signature
Date Received	Date Entered In Payroll System