

SALARY DEFERRAL AGREEMENT

Plan Name: _____

I. PARTICIPANT INFORMATION

Name: _____ Social Security #: _____

Address: _____

City, State Zip: _____

Date of Birth: _____

This is a: (check one) New enrollment Change

II. PARTICIPANT ELECTIONS

I authorize the Employer to deduct the following amount from my compensation each pay period and contribute the amount to my 401(k) Plan account.

A. Salary deferral amount. The Employer will withhold from my compensation (and treat as my deferrals) the following amount:

Percentage. _____% of my compensation, but not less than 1% and I must specify a whole percentage amount.

Dollar amount. \$_____.

Zero. I do not wish to defer any amount. I hereby terminate my prior Salary Deferral Agreement.

The Plan also permits me to make "catch-up" contributions if I am age 50 or older. These are additional amounts that I may defer regardless of any other limits imposed by the Plan.

I HEREBY APPLY FOR PARTICIPATION IN THE PLAN, THE PARTICULARS OF WHICH HAVE BEEN MADE AVAILABLE TO ME, AND FOR WHICH I AM ELIGIBLE. I AGREE TO THE TERMS AND CONDITIONS OF THE TRUST AND PLAN DOCUMENT. THIS APPLICATION IS MADE SUBJECT TO SAID TERMS AND I AGREE THAT I AND MY BENEFICIARIES, HEIRS, EXECUTORS, ADMINISTRATORS AND ASSIGNS WILL BE BOUND BY ALL OF THE TERMS AND CONDITIONS AND/OR ANY RULES AND REGULATIONS ADOPTED BY THE TRUSTEES. I UNDERSTAND THE EMPLOYER IS UNDER NO OBLIGATION TO CONTINUE THE PLAN.

THIS SALARY DEFERRAL AGREEMENT REMAINS IN EFFECT UNTIL I REVOKE OR MODIFY IT. I AM ALSO PERMITTED TO REVOKE MY AGREEMENT AT ANY TIME DURING THE PLAN YEAR.

I UNDERSTAND I HAVE A DUTY TO REVIEW MY PAY RECORDS (PAY STUB, ETC.) TO CONFIRM THE EMPLOYER PROPERLY HAS IMPLEMENTED MY SALARY DEFERRAL ELECTION. FURTHERMORE, I HAVE A DUTY TO INFORM THE PLAN ADMINISTRATOR IF I DISCOVER ANY DISCREPANCY BETWEEN MY PAY RECORDS AND THIS SALARY DEFERRAL AGREEMENT. I UNDERSTAND THAT MY FAILURE TO REPORT ANY DISCREPANCY MAY RESULT IN A LOSS OF OR REDUCTION IN MY ABILITY TO DEFER.

Dated this _____ day of _____, 20__.

Signature of Employee

Signature of Plan Administrator's Representative

PLEASE RETURN THIS FORM TO THE PLAN ADMINISTRATOR

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To be invested as follows: (Percentages must add to 100%)

_____ % to _____ _____ % to _____
_____ % to _____ _____ % to _____
_____ % to _____ _____ % to _____

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I UNDERSTAND I HAVE A DUTY TO REVIEW MY PAY RECORDS (PAY STUB, ETC.) TO CONFIRM THE EMPLOYER PROPERLY HAS IMPLEMENTED MY SALARY REDUCTION ELECTION. FURTHERMORE, I HAVE A DUTY TO INFORM THE PLAN ADMINISTRATOR IF I DISCOVER ANY DISCREPANCY BETWEEN MY PAY RECORDS AND THIS SALARY REDUCTION AGREEMENT. I UNDERSTAND THAT MY FAILURE TO REPORT ANY DISCREPANCY MAY RESULT IN A LOSS OF OR REDUCTION IN MY ABILITY TO DEFER.

Dated this _____ day of _____, 20__.

Signature of Employee

Signature of Plan Administrator's Representative

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