



**Supplemental Retirement Annuity (SRA)
403(b) Tax Deferred Annuity
Salary Reduction Agreement Form
University System of Maryland (USM)**

I, _____, SSN _____, elect to
(First Name Middle Initial Last Name)

(CHOOSE ONE ACTION): Enroll New____ Change participation____ Cancel participation____
in the SRA 403(b) Tax Deferred Annuity plan offered by the following company:

FIDELITY INVESTMENTS _____ **TIAA-CREF** _____

MD SUPPLEMENTAL RETIREMENT PLANS (MSRP) - Nationwide _____

To this 403(b) Tax Deferred annuity account, I elect to contribute \$ _____, bi-weekly. *This contribution amount will continue in subsequent calendar years if a new salary reduction agreement is not received. Please note that if this contribution is not being taken over 26 paychecks, it will be necessary for the employee to make an adjustment the following calendar year in order to avoid over-withholding.* I have also attached a completed Payroll Deduction Authorization Form as required to process this transaction.

This payroll salary action is expected to begin with the paycheck issued on _____, 20____ or on such later date as may be appropriate due to required payroll procedures.

If I am contributing to retirement plans through the Veterans Administration, a Faculty practice plan, or another employer, those contributions may affect the amount that I can contribute to a SRA. I understand that I should consult with the vendor on Internal Revenue Code (IRC) regulations contribution limitations.

In signing this form I also authorize the University to release employment information to the company selected above for the purposes of monitoring compliance of my account(s) with IRC regulations.

This agreement shall be legally binding and irrevocable as to each of the parties involved. However, either party may terminate this agreement as of the end of any month, so that it does not apply to subsequently earned salary, by giving at least 30 days written notice of termination.

The amount deferred hereunder will produce a total deferral that does not exceed the applicable limitations of the Internal Revenue Code.

Signature: _____ Date: _____

USM Institution: _____ Office Phone: _____

USM Benefits Coordinator: _____ Date: _____
(Institution Representative)

