SALARY REDUCTION/DEDUCTION AUTHORIZATION AND AMENDMENT FORM

457 Deferred Compensation Plan – PRE TAX

Pursuant to the provisions and conditions set forth on the bottom of this page, I hereby request and authorize the Payroll Department of Santa Clara County Office of Education to reduce my salary by, or in the event of an after tax contribution, to deduct from my salary, the amount indicated in Section A of this form and direct the amount of such reduction/deduction to the company indicated in Section C below.

SECTION - A

Employee Full Name: ______________________ Date of Birth: ______________

Social Security Number: ______________ Work Site: ______________ Date of Hire: ______________

Employee Contribution per Pay Period: $__________ ☐ 10 Pay ☐ 11 Pay ☐ 12 Pay ☐ Other __________

Effective Date of Change: ______/______/______ Employee Annual Contribution: $ ______________

SECTION - B

CHECK ALL THAT APPLY: ☐ Increase in Contribution Amount ☐ Decrease in Contribution Amount

☐ New Contribution ☐ Change in Company ☐ Additional Company ☐ Stop All Contributions

SECTION – C

#9516 American United Life 457 Plan* $__________ per mo.

AXA Equitable 457 Plan $__________ per mo.

#9517 FTJ Fundchoice 457 Plan $__________ per mo.

#9522 Industrial Alliance 457 Plan* $__________ per mo.

#9520 Life Ins Co of the Southwest 457 Plan $__________ per mo.

#9523 Pacific Life 457 Plan* $__________ per mo.

Plan Member Services 457 Plan $__________ per mo.

#9521 Security Benefit 457 Plan $__________ per mo.

SECTION – D

CANCELLATION REQUEST – Please cancel contributions to the following companies:

______________________ ______________________
Company Name Company Address

______________________ ______________________
Company Name Company Address

SALARY REDUCTION / DEDUCTION AMENDMENT TO EMPLOYMENT CONTRACT

I hereby agree to the terms of the Plan Agreement.

I hereby authorize my employer to deduct from my salary the amount specified above and to transmit the deduction to the above designated company or companies. This authorization will continue in effect until I submit a timely termination.

By signing this document, the Employee directs the to withhold at the above level and acknowledges that he/she has been advised by qualified tax counsel and agrees to indemnify and hold the District/Employer harmless from any and all taxes, penalties, and cost which may occur due to any over-withholding of tax sheltered annuity funds generated by this amendment to the employment contract.

The Employee hereby both authorizes the disbursing agent to recover any amount erroneously transmitted by it, from the company(ies) receiving the erroneous amount, and directs the company(ies) so affected immediately transmit those amounts to the disbursing agent.

The Employee agrees that the District/Employer shall have no liability whatsoever for any and all losses suffered by the Employee with regard to his/her selection of the investment; the terms of the investment; the selection of the insurance company or regulated investment company; the solvency of, operation of or benefits provided by said insurance company or regulated investment company; or his/her selection and purchase of shares of regulated investment companies.

The employer and the employee are the sole participants in the Plan.

Employee Signature: ______________________ Date: ______________

Advisor Name (if applicable): Employee Benefits Services Rep Phone: 408-978-1000

District/Employer Authorization: ______________________ Date: ______________

**Grandfathered, for existing participants only*