

Plan Name: _____

2014 Deferral Election Form
Please Print. Complete all applicable areas

Part I. Employee Information:

Name: _____ Social Security # _____
Address: _____ Date of Birth: ____/____/____
City: _____ State: ____ ZIP Code: _____

Part II. Deferral Election: New Change No Change
The 2014 maximum deferral amount is \$17,500.00.

I hereby authorize my Employer to reduce my salary annually or each pay period for:

Pre-Tax Deferrals: I elect to reduce my salary by _____% or \$_____, and contribute this amount as a pre-tax Elective Deferral.

I do not wish to have any part of my pay contributed to the Plan.

Part III. Catch-Up Contributions Election: New Change No Change
The 2014 catch-up contribution amount for age 50 and over is \$5,500.00.

I authorize my Employer to reduce my salary annually or each pay period.

Age 50 Catch-Up Contributions: I elect to reduce my salary _____% or \$_____, and contribute this amount as a pre-tax Elective Deferral.

Part IV. Election to Stop Deferral:

I hereby authorize my Employer to stop my payroll deductions under the Plan. I understand that I may not reactivate my payroll deductions until the first day of the next election period.

Pre-Tax Elective Deferrals

Part V. Authorization: By signing this election form, I confirm the elections that I have made AND that it will remain in effect until a new election form is submitted to the Plan Administrator. I acknowledge that I understand the terms of the Plan, as stated in the Summary Plan Description and other notices that I have received. I understand I have a duty to review my pay records to confirm that the employer has properly implemented my deferral election. I further understand that it is my responsibility to comply with the deferral limitations outlined in the Plan and in the Internal Revenue Code.

Participant's Signature

____/____/_____
Date

Part VI. Plan Administrator Acknowledgement:

Plan Administrator Signature

____/____/_____
Date

I hereby acknowledge receipt of this New Changed election form and verify the accuracy of the Employee's Information.

Date Received: ____/____/____

Original
Date of Hire: ____/____/____

Payroll Effective Date: ____/____/____

Rehired Date: ____/____/____

Please Return This Form To The Plan Administrator