



CEC-NA 403(b) Contribution Payroll Form



Plan Name: The Charismatic Episcopal Church of North America 403(b) Plan

Complete this form as submit to CEC-NA Plan Administrator, by email admin403b@cec-na.org or fax 516-887-4591

I - Plan Participant Information (required):

Name (First)	(Middle Initial)	(Last)	Social Security Number / Tax ID	
Date of Birth (mm/dd/yyyy)	Daytime Telephone Number		E-mail	
Street Address		City	State	Zip
Date of Hire:				

Note: If you've applied for a SSN or a TIN but haven't received it, enter the date on which you applied in the Social Security Number / Tax ID box above.

II - Reason for Salary Reduction (required):

- New Enrollment
 Change
 Terminate salary reduction

III - Elective Deferral Authorization (required):

Please complete this section based on options available to you in your plan. Check with your plan administrator for which options would apply. NOTE: The Employer reserves the right to reduce a participant's salary deferral election if necessary to ensure the plan's compliance with the Internal Revenue Code.

- Regular Compensation** - For deposit into the Plan for my benefit, I request that the below amount be deducted from my pay each pay period. (Choose either Fixed Dollar Amount or Percentage below):

- Fixed Dollar Amount (choose all that apply):

Before-tax amount: \$ _____

Roth amount: \$ _____

- Percentage – whole % only (choose all that apply):

Before-tax amount: _____%

Roth amount: _____%

- Bonus Compensation** - For deposit into the Plan for my benefit, I request that the below amount be deducted from my bonus compensation. (Choose either Fixed Dollar Amount or Percentage below):

- Fixed Dollar Amount (choose all that apply):

Before-tax amount: \$ _____

Roth amount: \$ _____

- Percentage – whole % only (choose all that apply):

Before-tax amount: _____%

Roth amount: _____%

IV - Signature of Plan Participant or Recipient (required):

I understand that this salary reduction agreement shall remain in effect until I revoke or change it in writing. By signing below, I certify that the information I have provided in the preceding sections above is accurate and complete. I further certify that the number shown on this application is my correct Social Security Number / Taxpayer Identification Number.

WAIVER: If I have chosen to waive participation, in the above-named plan, I hereby acknowledge that I have been offered the opportunity to participate in the Plan and to make salary deferral contributions and I have waived my option to participate at this time. I understand that this election to waive participation will remain in effect until such time as I make another election in writing. I release and hold harmless the Plan Administrator, the Employer and the custodian of the Plan from and against any claims I may have with respect to my election not to contribute to the Plan.

X_____
Plan Participant/Recipient signature_____
Print name_____
Date**V - Signature of Plan Administrator (required):**

I certify that the individual referenced in section I – Plan participant information is a Participant under the plan.

X_____
Plan Administrator signature_____
Print name_____
Date

Return completed form to your Plan Administrator/TPA for processing and retain a copy for your personal records.