EQUITABLE

# 457(b) Employee Deferred Compensation Plan Salary Reduction Agreement

## (For Pre-Tax 457(b) and/or After-Tax Roth 457(b) Contributions)

For Assistance Call: (800) 528-0204
www.equitable.com

**Return via Mail or Fax:**
Equitable-Retirement
PO Box 219489
Kansas City, MO 64121-9489

**Street and Overnight Address:**
Equitable-Retirement
430 W. 7th Street STE 219489
Kansas City, MO 64105-1407

**Fax Number:**
(816) 218-0412

**Note:** This Agreement should be completed by the Employee and returned to the Employer.

EMPLOYEE NAME:_____ DATE OF BIRTH:_____ (MM/DD/YYYY)

SOCIAL SECURITY NUMBER or EMPLOYEE ID:_____

EMPLOYER NAME:_____ Date of Employment: ____/____/____

Current Annual Salary: $_____ ☐ New Agreement ☐ Contribution Change ☐ Cancel Salary Reduction

## I. Deferral Election

As an eligible participant in the 457(b) plan sponsored by the Employer ("Employer's 457(b) Plan"), the Employee hereby enters into this salary Reduction Agreement with the Employer to contribute amounts to purchase an annuity contract offered under the Employer's 457(b) Plan, and the parties hereto agree as follows:

The Employee authorizes the Employer to reduce the Employee's compensation on a ☐ Monthly ☐ Per Pay Period effective on _____* (MM/DD/YYYY)

**NEW TOTAL** of: **Pre-Tax 457(b) $** _____ **Or** _____**% of my pay**

**After-Tax Roth 457(b)** $** _____ **Or** _____**% of my pay**

**Catch-Up Option being utilized, if any:** ☐ **Age 50+**** -OR- ☐ **Last 3 Years of Service****

**(With very limited exception, the Code requires that this agreement be received by the Employer before the first day of the month in which contributions will begin or change. If necessary to meet that requirement, the Employer reserves the right to change the effective date of contributions.)*

**Contact your Employer to determine eligibility.

## II. Acknowledgement

1. It is understood and agreed between the parties that the annuity contract(s) purchased hereunder shall be the sole and exclusive property of the Employer. The undersigned Employee shall hold harmless and indemnify the Employer, its governing board, its officers and employees, from every claim and demand, which may be made by reason of his or her purchase of and the holding of Equitable Financial Life Insurance Company employee deferred compensation annuity contracts.
2. This Agreement is legally binding and irrevocable with respect to salary reduction amounts earned while this Agreement is in effect, and shall supersede and prior salary reduction agreement between the Employee and the Employer under the Employer's EDC Plan. This Agreement will remain in force until any one of these events occurs:
   a) Written notification of termination of this Agreement (including signing a new agreement), with at least 30 days advance notice, is received by the Employer;
   b) The Employee terminates employment with the Employer for any reason including the Employee's death or disability;
   c) The Employer terminates sponsorship of the Employer's EDC plan; or
   d) The Employer ceases to qualify as an entity eligible to maintain an EDC plan.

   Any termination of this Agreement will not affect salary reduction amounts credited to the Employee's annuity contract prior to the date of such termination.

## II. Acknowledgement (Continued)

3. It is understood that the IRS limits the annual salary reduction contributions that an individual can make under this plan and all other affected plans to which the individual is eligible to contribute under the Internal Revenue Code. In the event that salary reduction contributions exceed the maximum IRS limits, the employee agrees to reduce, or receive a refund of, the amount of salary reduction contributions required to comply with the federal tax limitations. The Employee agrees to provide any and all information reasonably required by the Employer, or party designated by the employer and Equitable in connection with the Employee's purchase of an annuity contract hereunder, including, without limitation, information on current and historical contributions to other companies, and/or participation in any other qualified plan or any other 457(b) plan, and to contact his or her financial professional as soon as possible if the Employee's employment status and/or compensation changes at any time after this Agreement takes effect.

***I understand the following:*** My employer will include any Designated Roth Contributions in my taxable income, will withhold tax, and will include these amounts on my Form W-2. These contributions will be separately accounted for within my Contract/Certificate.These contributions will have the same investment allocation as my other funds under the Contract/Certificate. The designated Roth portion of my account will be subject to the same rules as those pre-tax salary reduction amounts in the Contract/Certificate.

**AGREED TO BY THE EMPLOYEE:**

X _____ Date: _____

EMPLOYEE SIGNATURE

_____ Contract Number _____

Financial Professional Name / Phone#

EQUITABLE

# Retirement Gateway® 457(b) Designation or Change of Beneficiary Form

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**PLEASE PRINT**

## 1. Participant Information

First Name, Middle Initial | Last Name | Social Security Number

Daytime Phone Number | Mobile Number | Email Address

Is the Participant married? ☐ Yes ☐ No Date of Birth (mm/dd/yyyy) ____/____/____

Monroe Municipal Utilities Authority
Employer's Name

693820
Contract ID Number

## 2a. Primary Beneficiary Designation

I hereby designate the following as my beneficiary(ies) under my employer's plan subject to my right to change this designation as provided in said Plan:

**Primary Beneficiary(ies)** ***(If more than one, indicate %)***

**Primary Beneficiary #1** | % | Social Security Number | Relationship to Participant

Address | Date of Birth | Phone Number

**Primary Beneficiary #2 (Optional)** | % | Social Security Number | Relationship to Participant

Address | Date of Birth | Phone Number

**Primary Beneficiary #3 (Optional)** | % | Social Security Number | Relationship to Participant

Address | Date of Birth | Phone Number

## 2b. Contingent Beneficiary Designation

I hereby designate the following as my contingent beneficiary(ies) under my employer's plan subject to my right to change this designation as provided in said Plan:

**Contingent Beneficiary(ies)** ***(If more than one, indicate %)***

**Contingent Beneficiary #1** | % | Social Security Number | Relationship to Participant

Address | Date of Birth | Phone Number

**Contingent Beneficiary #2 (Optional)** | % | Social Security Number | Relationship to Participant

Address | Date of Birth | Phone Number

**Contingent Beneficiary #3 (Optional)** | % | Social Security Number | Relationship to Participant

Address | Date of Birth | Phone Number

## 3. General Provisions

1. Except to the extent otherwise expressly provided on the face of this Designation, all sums payable under the Plan to a beneficiary(ies) at or by reason of the death of the participant:
   (a) Shall be equally divided between such of the primary beneficiaries named on the face of this Designation as survive the Participant, except where a non-surviving primary beneficiary has been survived by a contingent beneficiary or beneficiaries who were living at the time of the Participant's death. Such beneficiaries shall receive the share such primary beneficiary would have received if he or she had survived the Participant.
   (b) If any primary beneficiary is not living at the time of the Participant's death, his or her share of such payment shall be equally divided between such of the contingent beneficiaries designated for such primary beneficiary who are living at the time of the Participant's death.
   (c) If upon the death of a person there is no designated beneficiary then living entitled to receive any amount which becomes payable to a beneficiary, such amount shall be payable to the first surviving class of the following classes of successive preference beneficiaries: (1) the Participant's widow or widower; (2) the Participant's surviving children; (3) the Participant's surviving parents; (4) the Participant's surviving brothers and sisters; (5) the executors or administrators of the person upon whose death the payment becomes due.
   (d) By expressly providing on the face of this Form the manner in which you wish your beneficiary designation to be executed, you may override the provisions outlined in a, b or c above.
2. A Beneficiary Designation or Change dated and signed by the Participant and witnessed by a Plan Representative or a Notary Public shall be valid upon receipt by the Plan Administrator of said notice and shall be effective as of the date shown on said notice as the date on which it was signed, whether or not the person making such Designation or Change is living at the time of receipt, but without further liability on the part of the Employer or Employer's Designee and the Insurer with respect to any payment made before receipt of said notice.
3. The terms, provisions and limitations of the Plan and any amendments thereof which may hereafter be made from time to time are controlling over the above-stated General Provisions and shall govern all the rights of the Participant, his or her designated beneficiaries, and any person claiming rights under such Agreements.

**IMPORTANT NOTICE:** This beneficiary designation under the plan should be carefully reviewed from time to time as changes occur in the law or in your personal or financial situation. Please advise us if any of your beneficiaries change their addresses.

## 4. Signatures/Authorization

This designation is subject to the General Provisions below.

X _____ _____

Signature of Participant — Date

X _____ _____ _____

Signature of Employer or Employer's Designee (if required by the Plan. Confirm with Plan Administrator) — Print Name — Date