

**STEP 1: TELL US ABOUT YOURSELF**

Choose the appropriate title:  Mr.  Mrs.  Miss  Ms.  Dr.  Other \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Employee ID# \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of hire: \_\_\_\_/\_\_\_\_/\_\_\_\_  Married  Not married  
 Daytime phone \_\_\_\_\_ Department \_\_\_\_\_

**STEP 2: TELL US IF YOU WANT TO CONTRIBUTE** (Select one option only)

I elect to contribute through salary deferrals to the vendor indicated below:

**Lincoln Financial**

Pre-tax contributions \$ \_\_\_\_\_ or \_\_\_\_\_ %  
 Roth after-tax contributions \$ \_\_\_\_\_ or \_\_\_\_\_ %

**TIAA-CREF**

Pre-tax contributions:  
 Defined contribution \$ \_\_\_\_\_ or \_\_\_\_\_ %  
 Supplemental/tax deferred annuity \$ \_\_\_\_\_ or \_\_\_\_\_ %  
 Roth after-tax contributions:  
 Supplemental/tax deferred annuity \$ \_\_\_\_\_ or \_\_\_\_\_ %

I OPT OUT of the Automatic Enrollment Provision

**STEP 3: READ THESE STATEMENTS CAREFULLY**

- The employer will reduce your pay by the amount indicated (in **Step 2** above) per pay period, or if no election is made will reduce your pay by 5% under the Automatic Enrollment provision. The employer will send this amount to Lincoln Financial as contributions.
- The first payroll deduction under the Automatic Enrollment Provision will take place the first payroll following 30 days of employment.
- While employment continues, this agreement legally binds both you and the employer for amounts deferred while it is in effect. A new agreement must be submitted to change your percentage.
- This agreement will apply only to eligible salary not yet currently available to you. It will not apply to any amounts earned after the agreement is terminated.
- If you do not provide investment choices, your contributions will be invested in the Time Based *LifeSpan*® Model, assigned by birth year.

**STEP 4: SIGN YOUR NAME**

By signing below, I certify that I have read, understand and agree to the terms of the **Salary Reduction Agreement**. The signature of the plan administrator certifies that the plan administrator also agrees to the **Salary Reduction Agreement**.

\_\_\_\_\_  
Participant's signature Date

\_\_\_\_\_  
Plan administrator's signature Date

**FOR HR USE ONLY**

Deduction Code	Rate Entered	Effective Pay Date	Date Processed	Processed By

**Return this form to:**

**Florida Institute of Technology ■ Office of Human Resources**

150 West University Boulevard, Melbourne, FL 32901-6975 ■ (321) 674-8100 ■ Fax (321) 674-7519

E-mail hr@fit.edu ■ www.fit.edu/hr