



Cortland County Community Action Program, Inc.

**401(k), 403(b), TAX-  
DEFERRED ANNUITY or SIMPLE IRA PLAN SALARY REDUCTION AGREEMENT**

\_\_\_\_\_  
Employee Name

XXX-XX-\_\_\_\_\_  
Last 4 Digits of Social Security Number

The Plan has been explained to me, and I have been given a Summary Plan Description. I understand that I may voluntarily choose to have my pay reduced for contributions to the Plan.

**ELECTION TO CONTRIBUTE**

I elect to designate my contributions as Traditional PreTax Contributions and contribute \_\_\_\_\_ % of my pay, and I authorize my employer to deduct that amount each pay period.

I am aware that:

- 1.) My contribution may be reduced in order to comply with Federal tax rules and limits, including any higher limits that apply to participants age 50 and older.
- 2.) This election will take effect the first pay period beginning on or after the first day of each quarter: January 1, April 1, July 1, October 1 or as soon as administratively feasible for my employer to begin deductions from my pay after I file this Salary Reduction Agreement with my employer. I may stop or change my election for future pay periods by giving my employer written notice, which will take effect as soon as administratively feasible.
- 3.) My contributions and earnings cannot be withdrawn or paid until I attain age 59 ½ or upon my death, disability, or termination of employment. My contributions may be available for withdrawal in the event of serious financial hardship (according to the Plan and IRS rules)
- 4.) This election generally applies to all compensation payments that I receive, as described in my employer's Plan document

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

EMPLOYER REPRESENTATIVE: \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

**ELECTION NOT TO CONTRIBUTE**

I do not wish to contribute to the Plan at this time. I understand that if the Plan provides for matching employer contributions, I will not be entitled to such contributions during the time I am not contributing. I also understand that I may elect to contribute in the future by completing a Salary Reduction Agreement and an Enrollment Form and filing them with my employer.

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

EMPLOYER REPRESENTATIVE: \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

**NOTE TO EMPLOYERS**

**THIS FORM SHOULD BE RETAINED WITH THE EMPLOYER'S RECORDS OF THE PLAN.  
EMPLOYERS SHOULD REVIEW THIS SAMPLE PAYROLL AUTHORIZATION FORM WITH  
LEGAL COUNSEL, IN PARTICULAR REGARDING ANY APPLICABLE STATE LAW THAT MAY  
AFFECT THIS DOCUMENT.**

MUTUAL OF AMERICA LIFE INSURANCE COMPANY, 320 PARK AVENUE, NEW YORK, NY 100226839