Research Foundation for Mental Hygiene, Inc. (RFMH)
403(b) Salary Reduction Agreement

Employee Name _____ SS Number _____

☐ Original Agreement ☐ Amended Agreement

This agreement is made between _____ and RFMH.
(Employee's Name)

A. EFFECTIVE DATE

The following election to participate in either type of Tax-Deferred Account will be effective for:

☐ Option 1: The next available pay period.
☐ Option 2: specify pay period _____

The employee's compensation will be reduced by the amount or percentage indicated below and allocated as designated below by the Employee. These contributions will be deducted on a bi-weekly pay period basis.

B. SELECT/CHANGE CONTRIBUTION AMOUNT (a)

☐ Reduce my gross compensation by:

$ _____ fixed dollar amount) **or** _____ % (percentage) **per pay** period for deposit in my 403(b) account.

Allocate the amount/percentage between Pretax and Roth below. Total must equal above.

Traditional Salary Deferral 403(b) Pre-Tax Contributions Dollar
DollarAmount/Percentage _____
Roth 403(b) Post-Tax Contributions
DollarAmount/Percentage _____

(a) 2019 Contribution Limits; Under Age 50 $19,000, Age 50 and Over $25,000

C. EMPLOYEE AGREEMENT

I understand that this Salary Reduction Agreement replaces any earlier agreement and will remain in effect until (1) a new agreement is submitted, (2) the maximum annual elective deferral is met each year, or (3) I am no longer an eligible Employee under the RFMH 403(b) Salary Deferral and Defined Contribution Plan.

I understand I am responsible for the accuracy of the excludable amounts stated in this Agreement; for monitoring the accuracy of the dollar amount to be deferred on an annual basis; for any overstatement of the amounts excludable as a salary reduction in this agreement, or any other violation of the requirement of Sections 403(b), 402(g), and/or 415, Internal Revenue Code (IRC); for any additional taxes, interest, and penalties that may be assessed. I also understand that I bear the risk of the performance of the product(s) of my choosing, that RFMH has no fiduciary responsibilities in this area, and that RFMH is not liable for any tax consequences occurring under this program.

I understand that I am responsible for reviewing Fee Disclosure Policy, Summary of Plan Services and Costs, and the Investment Options Comparative Chart for the RFMH Tax Deferred Annuity (TDA) and Frozen Defined Contribution Plan. The Plan number associated with this Plan is 102539.

_____ _____

Employee Signature Date

D. TO BE COMPLETED BY HUMAN RESOURCES

Processed by:_____ Date: _____