

**SALARY REDUCTION AGREEMENT**

\_\_\_ Original Agreement

\_\_\_ Amended Agreement

By THIS AGREEMENT, made between \_\_\_\_\_ (Employee) and FLORIDA INTERNATIONAL UNIVERSITY (Employer), the parties hereto agree as follows:

Effective with respect to amounts paid on \_\_\_\_\_ (which date is subsequent to the execution of the Agreement), the Employee's salary will be reduced by the amount indicated below and allocated to the Company (ies) designated below by the Employee.

This Agreement is legally binding and irrevocable for both the institution and the Employee with respect to the amounts earned while it is in effect. This Agreement is not a contract of employment between the Employee and the Employer, and no provision of the Agreement shall restrict the right of either party to effect termination of employment. The Employee may make changes to this Agreement by completing a new Salary Reduction Agreement.

**The Employee is 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 and any other violation of the requirement of Sections 403(B) 402(g) and/or 415, Internal Revenue Code (IRC). Additionally, the Employee is also responsible for any additional taxes, interest, and penalties that may be assessed.**

**Payroll Reduction  
 Biweekly Amounts**

**COMPANY NAME**

VALIC (ORP Provider)	TVA	\$	<i>For Benefits office use only</i>  PPE ENDING _____
ING LIFE INSURANCE & ANNUITY CO. (ORP Provider)	TIN	\$	
JEFFERSON NATIONAL (ORP Provider)	TJE	\$	
METLIFE INVESTORS (ORP Provider)	TME	\$	
TIAA-CREF (ORP Provider)	TTI	\$	
ING RELIASTAR	TNO	\$	
SYMETRA FINANCIAL	TSY	\$	
FIDELITY INVESTMENTS*	TFI	\$	
T.ROWE PRICE*	TRO	\$	
VANGUARD FIDUCIARY*	TVG	\$	

Please note that once the annual IRS limit voluntary contributions from FIU to your accounts are met, they will stop automatically. However, they will restart at the same *level* of contribution on the following calendar year if not adjusted.

**DISCLAIMER:** I have completed and submitted the required account application(s) for the vendor(s) selected. I understand that failure to complete the vendor application will result in my contribution(s) being returned. I understand that I am responsible for determining that the amount of my salary reduction listed above does not exceed the limits on contributions. \_\_\_\_\_ (Employee's initials)

Signed by: \_\_\_\_\_ Employee ID \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Completed Enrollment: _____ Benefits Representative	Date: ____/____/____
Audited by: _____ Initials	Date: ____/____/____