



Choice Plan 401(k)

ENROLLMENT FORM

Please choose one: Initial Authorization Change of Authorization

PARTICIPANT AUTHORIZATION - PLEASE CHECK 1 OR 2

1. I authorize my employer to reduce my wages by the following amount, for deposit into the PERSI Choice Plan 401(k) account established for my benefit:

- An amount equal to _____ %*of my gross wages each pay period. Percentages must be whole percentages from 1% to 100%.**
- A flat amount of \$_____ from my gross wages each pay period. ***

* As of January 1, 2006, the annual contribution limit for the 401(k) is \$15,000, (\$20,000 if you are at least 50 years of age in 2006). If you contribute to both a 457 and 401(k), you may contribute up to \$15,000 (\$20,000 if age 50) into **each** plan, for a total of \$30,000 (\$40,000 if age 50). If you contribute to both a 403(b) and a 401(k), the **combined** annual contribution limit is \$15,000 (\$20,000 if at least age 50).

** Because of additional mandatory (FICA and PERSI) and voluntary (Health Insurance, Flex Plan, etc.) payroll deductions, you may not actually be able to defer 100% of your gross wages.

***Before making this selection, confirm your employer's payroll system is programmed to deduct a flat dollar amount rather than a percentage deferral from your wages.

- This authorization applies to future contributions only. It will be effective as of (pay date) _____ and will remain effective until I change or stop it by completing a new Enrollment Form.
- I understand that distributions from the PERSI Choice Plan are only allowed in the event of termination of employment, disability, retirement, death, or financial hardship. Financial hardship distributions are allowed only under certain IRS-approved circumstances.
- I understand that my contributions will automatically default into the PERSI Total Return Fund until I change my investment allocation via the Voice Response System or website.

2. I elect to **stop** my contributions to the PERSI Choice Plan 401(k). I may begin them again later by completing a new Enrollment Form

PARTICIPANT SIGNATURE After completion, give form to your employer's Human Resources or Payroll Department.

I authorize the above action.

Participant Name (please print)

Social Security Number

Participant Signature

Date

EMPLOYER AGREEMENT

The employer agrees to the terms stated above.

Department Personnel or Payroll Officer Signature

Date