

The Johns Hopkins Health System Corporation 403(b) Plan

Salary reduction agreement

TYPE OR PRINT ALL INFORMATION • PARTICIPANT SHOULD NOT WRITE IN SHADED AREAS

PART 1 Tell us about yourself	Choose the appropriate title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other _____		Employer Code <input type="checkbox"/> JHH <input type="checkbox"/> JHHS <input type="checkbox"/> JHBMC		
	Name:				
	Last	First		Middle	
	Address:				
	Street				
	City			State	Zip
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Not Married			SS#:	
	Date of Birth:			Date of Hire:	
Daytime Phone: ()		Evening Phone: ()			

PART 2 Tell us if you want to participate	<input type="checkbox"/> I want to participate.	Tell us what amount of your salary you want to contribute (in whole numbers): _____ % or \$ _____
	The first payroll deduction will take place as soon as administratively possible after we receive this form.	

PART 3 Read these statements carefully	<ul style="list-style-type: none"> The employer will reduce your pay by the amount indicated (in Part 2 above) per pay period. The employer will send this amount to the provider as contributions toward a 401(a), 401(k), or 403(b) plan or program. Until your investment election is received, the funds will be held in the default investment option designated by Johns Hopkins Health System Corporation, the <u>moderate lifestyle asset allocation model</u>. The first payroll deduction will take place as soon as administratively possible after we receive this form. 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 amounts not yet currently available to you. It will not apply to any amounts earned after the agreement is terminated.
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PART 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 .
	X _____ Participant's signature Date

Return to:	Johns Hopkins Health System Corporation Processing Agent c/o Administrative Management Group or Your designated Lincoln Retirement Consultant 3800 N. Wilke Road, Suite 250 Arlington Heights, IL 60004-9915
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