Supplemental Retirement Annuity (SRA)  
403(b) Tax Deferred Annuity  
Salary Reduction Agreement Form  
University System of Maryland (USM)

I, ______________________________________, SSN ____________________, elect to
(First Name Middle Initial Last Name)

(CHOOSE ONE ACTION):  Enroll New____  Change participation____  Cancel participation____
in the SRA 403(b) Tax Deferred Annuity plan offered by the following company:

FIDELITY INVESTMENTS _______  TIAA-CREF ________  
MD SUPPLEMENTAL RETIREMENT PLANS (MSRP) - Nationwide ________  

To this 403(b) Tax Deferred annuity account, I elect to contribute $___________, bi-weekly.  This
contribution amount will continue in subsequent calendar years if a new salary reduction agreement is
not received.  Please note that if this contribution is not being taken over 26 paychecks, it will be
necessary for the employee to make an adjustment the following calendar year in order to avoid over-
withholding.  I have also attached a completed Payroll Deduction Authorization Form as required to
process this transaction.

This payroll salary action is expected to begin with the paycheck issued on __________, 20___ or on such
later date as may be appropriate due to required payroll procedures.

If I am contributing to retirement plans through the Veterans Administration, a Faculty practice plan, or
another employer, those contributions may affect the amount that I can contribute to a SRA.  I understand
that I should consult with the vendor on Internal Revenue Code (IRC) regulations contribution limitations.

In signing this form I also authorize the University to release employment information to the company
selected above for the purposes of monitoring compliance of my account(s) with IRC regulations.

This agreement shall be legally binding and irrevocable as to each of the parties involved.  However, either
party may terminate this agreement as of the end of any month, so that it does not apply to subsequently
earned salary, by giving at least 30 days written notice of termination.

The amount deferred hereunder will produce a total deferral that does not exceed the applicable limitations
of the Internal Revenue Code.

Signature: ________________________________ Date: ___________________________

USM Institution: ____________________________ Office Phone: _____________________

USM Benefits Coordinator: ____________________________ Date: _____________________
(Institution Representative)

USM Form-RV – 403(b) – SRA – Salary Reduction Agreement Form - Revised 03/12/09
UNIVERSITY SYSTEM OF MARYLAND EMPLOYEES

Deduction Authorization Form for Enrollment/Change/Cancellation in:

FIDELITY INVESTMENTS 403(b) Supplemental Retirement Plan (SRA)

Please print or type all information in BLACK INK for electronic imaging.

Payroll System – Check One:  □ Regular  □ Contract  □ University of Maryland

Human Resources/Payroll Agency Code

(See your pay stub for this information)  Institution Name (Place of Employment)

Social Security Number  Employee Name

Important Notes: This form is used to establish or change the employee’s elected contribution amount for biweekly deductions. This form is valid only when signed by both the employee and the Institution Benefits Coordinator.

<table>
<thead>
<tr>
<th>Deduction Action Requested</th>
<th>Name of SRA Plan</th>
<th>CPB Deduction Code</th>
<th>Payroll Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Initiate</td>
<td>FDLTY 403(b)</td>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>

Employee Total Biweekly Deduction Amount

Current Amount $  

New Amount $  

Deduction will begin on the next available pay period upon receipt of this form at the State Central Payroll Bureau.

Effective upon receipt at the State Central Payroll Bureau, I authorize the State of Maryland to deduct from my salary the above amount and forward it to the company listed. This authorized amount is to continue until a change is submitted by me to my Institution Benefits Coordinator on a new authorization form. Timing for the application of this action is dependent upon when it is received by the State Central Payroll Bureau. In the case of an initial enrollment, upon receipt of the funds, the vendor shall establish an account with a LifeCycle Fund.

Employee’s Signature ___________________________  Date __________  Place of Employment __________________________________________________________________________________________

Benefits Coordinator’s Signature ___________________________  Date __________  Benefits Coordinator’s Phone Number ___________________________

(In the case of an initial enrollment, my signature below assures that I will be sending this form to the UM System Payroll/Central Payroll Bureau. Upon receipt of the funds from CPB, the vendor shall establish an account with a LifeCycle Fund and notify the employee immediately via mail.)