Salary Deferral Agreement
403(b) Plan

MetLife®

SOMERSET MEDICAL CENTER 1013358-01

Participant Information

Last Name | First Name | MI

Social Security Number

Address - Number & Street

E-Mail Address

City | State | Zip Code

Mo Day Year

Date of Birth

❑ Female ❑ Male

❑ Married ❑ Unmarried

( ) Home Phone

( ) Work Phone

Salary Deferral Agreement

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superceded, or the employee ceases to be an eligible employee. This Agreement supercedes all previous agreements.

I understand that I may change the percentage of compensation or dollar amount contributed to the Plan only when and as allowed under the terms of the Plan. I also understand that it is my responsibility to comply with the Internal Revenue Code (the "Code") deferral limits.

Payroll Information

Specify one of the following:

❑ New Enrollment ❑ Restart ❑ Increase Payroll Deduction ❑ Decrease Payroll Deduction ❑ Stop Deductions

Specify the following:

Before-Tax - The amount that you may contribute is 1% - 100% OR $1.00 - $16,500.00 of your compensation, whichever is less. The amount that you may contribute is not to exceed the annual maximum contribution allowable under the Code and applicable regulations and/or the provisions of your Plan.

❑ I hereby authorize the company to deduct _____% **OR** $_____ (do not complete both) (per pay period) of my compensation as before-tax contributions. I understand that these contributions will be withheld from my paycheck and contributed by the employer to the Plan on my behalf for allocation to my before-tax account.

❑ I hereby elect not to contribute before-tax dollars to the retirement Plan and thereby do not authorize any deduction of before-tax dollars from my paycheck. Any prior payroll withholding authorization to withhold before-tax dollars is hereby cancelled.

Payroll Effective Date: Mo Day Year

Date of Hire: Mo Day Year

Required Signature(s) - I have completed, understand and agree to the terms of this Agreement and authorize the payroll deduction as indicated on this form.

Participant Signature **Date**

Authorized Plan Administrator Signature **Date**

Participant forward to Plan Administrator