



UNIVERSITY SYSTEM OF MARYLAND EMPLOYEES

Deduction Authorization Form for Enrollment/Change/Cancellation in: **TIAA-CREF 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)

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Social Security Number

Employee Name

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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.

Deduction Action Requested	Name of SRA Plan	CPB Deduction Code	Payroll Cycle
☐ Initiate	TIAA 403(b)	40	Deduction will begin on the next available pay period upon receipt of this form at the State Central Payroll Bureau.
☐ Change	Employee Total Biweekly Deduction Amount		
☐ Cancel	Current Amount	\$	
	New Amount	\$	

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.

Employee's Signature

Date

Place of Employment

(In the case of an initial enrollment, my signature below assures that I have forwarded an employee-signed 403(b) enrollment form to the TIAA-CREF vendor, prior to this form being submitted to the UM System Payroll/Central Payroll Bureau. Upon receipt of the form, the vendor shall notify the Benefits Coordinator immediately via FAX.)

Benefits Coordinator's Signature

Date

Benefits Coordinator's Phone Number



**Supplemental Retirement Annuity (SRA)
403(b) Tax Deferred Annuity
Salary Reduction Agreement**
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 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 Card 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)