# Salary Reduction Agreement

## Adfinitas Health 401(k) Retirement Plan RK-662523

| Employee Full Name (please print) | SSN |
|---|---|
| | |

**Participant Contribution Election.** I authorize my employer to deduct the following amount from my eligible compensation each payroll period for deposit into the Plan.

☐ Regular deferrals (*pre-tax)*: I understand the amount of deferrals I have elected in this Salary Reduction Agreement will reduce my current compensation which is includible in income for the taxable year of the deferral.

Deduct _____% **or** $_____of eligible compensation.

☐ Roth deferrals *(after-tax)*: I understand the amount of deferrals I have elected in this Salary Reduction Agreement will NOT reduce my current compensation which is includible in income for the taxable year of the deferral.

Deduct _____% **or $**_____ of eligible compensation.

☐ Split deferral election: A portion of my deferrals as Regular deferrals and a portion of my deferrals as Roth deferrals.

Deduct _____% **or $**_____ of eligible compensation as Regular deferrals.
Deduct _____% **or $**_____ of eligible compensation as Roth deferrals.

☐ I do not wish to contribute to the Plan at this time.

(If you are age 50 or older, or will be by the end of the calendar year, and would like to contribute catch-up contributions, please contact your employer.)

**Employee Signature.**

I request that my participation in the above-named Plan be made according to this direction until I initiate a change. I understand federal law and Plan provisions may limit my salary reduction amount. I authorize the Plan Administrator to make adjustments as may be required to conform to Plan provisions and applicable law. I understand I have a duty to review my pay records (ex. pay stub) to confirm the Employer properly implemented my salary reduction election. I also understand I have a duty to inform the Plan Administrator if I discover any discrepancy between my pay records and my contribution election and that failure to report any discrepancy may result in a loss of or reduction in my ability to defer.

**EMPLOYEE SIGNATURE** **DATE**

**Authorized Signature**. As an authorized signer for the Plan, I acknowledge the receipt of this Salary Reduction Agreement.

**AUTHORIZED SIGNATURE** **DATE**

**Note:** Changes to your investment election must be made electronically by telephone or internet.

Authorized Signer: Please retain the original.
No copy needed to Alerus Retirement Solutions.