



**look  
forward to  
retirement!**

# Salary Reduction Form

**Personal Information**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First MI  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Telephone (work) \_\_\_\_\_ Telephone (home) \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Employer Phone \_\_\_\_\_

**Salary Reduction**

**Designate your pretax salary reduction**

AIG Retirement \$ \_\_\_\_\_/Check  
 Hartford Life \$ \_\_\_\_\_/Check  
 Horace Mann \$ \_\_\_\_\_/Check  
 ING \$ \_\_\_\_\_/Check  
 Security Benefit \$ \_\_\_\_\_/Check  
 TIAA-CREF \$ \_\_\_\_\_/Check

**Designate your post-tax (Roth-if available) deduction**

AIG Retirement \$ \_\_\_\_\_/Check  
 Hartford Life \$ \_\_\_\_\_/Check  
 Horace Mann \$ \_\_\_\_\_/Check  
 ING \$ \_\_\_\_\_/Check  
 Security Benefit \$ \_\_\_\_\_/Check  
 TIAA-CREF \$ \_\_\_\_\_/Check

**Effective Date**

First Available Paycheck  \_\_\_\_\_  
 Paycheck effective date

**Employer Contributions (if applicable)**

AIG Retirement  Hartford Life  Horace Mann  
 ING  Security Benefit  TIAA-CREF

**Employee Signature**

I authorize my employer to reduce my salary as requested. I understand and agree to the terms and conditions of the Retirement Investors' Club (RIC). I have access to a Program Summary, a Provider Summary, and a Plan Document. I have contacted my selected provider and have opened an account. I understand that withdrawals may only be made upon termination of covered employment or if I am eligible for one of the 403b approved in-service withdrawals stipulated by my employer's plan. I understand that the maximum amount of salary reduction may not exceed the federal limits required by Internal Revenue Code section 403(b).

\_\_\_\_\_  
 Signature Date

**Advisor Information**

(not required for existing accounts or online provider enrollment)

I certify that I am authorized by this provider to open accounts for RIC participants. The participant has completed the provider's paperwork to open an account.

\_\_\_\_\_  
 Print Advisor's Name Advisor's Signature  
 \_\_\_\_\_  
 Phone Number Date

**Instructions**

For access to the Program Summary, a Provider Summary, and the Plan Document, go to <http://das.hre.iowa.gov/ric.html>. Please give this form to the person responsible for your payroll.

