



The University of Akron
457 Plan Salary Reduction Agreement – Short Form

NOTE: This form is to be used to modify or cancel a 457 Plan Salary Reduction Agreement. If you do not currently have an Agreement on file for this Provider/Carrier, please use the 457 Plan Salary Reduction Agreement – Original Agreement available from your agent or at www.uakron.edu/controller.

Provider/Carrier Name _____

Employee Name: _____

Employee ID or SSN: _____

Beginning Payroll Date: _____

Pay Basis: ___ 9 MO. ___ 12 MO. ___ BI-WEEKLY

___ I wish to change my amount per pay from: \$_____00 to \$_____00.
(Please attach documentation from the Provider/Carrier demonstrating eligibility and corresponding computation.)

___ I wish to cancel my 457 Salary Reduction Agreement.

I (Employee) authorize the University of Akron to reduce my salary as stated above. The exclusion allowance has been calculated by the Provider/Carrier, and I agree to hold the University harmless in the event the I.R.S. should deem the calculation to be in error. The University of Akron will consider this salary reduction agreement in effect through the remainder of this calendar year and will automatically renew this agreement January 1 of each year thereafter unless the Employee notifies the University, by completing a new agreement, no later than 14 business days prior to the effective payroll date to be either terminated or modified.

Provider/Carrier Agent Signature (required) Date

Employee Signature (required) Date

Return to: The University of Akron, Payroll Office, 302 E. Buchtel Common, Akron, OH 44325-6210

For Payroll Office Use Only:

Action taken by: _____ Date: _____

Copy to Employee: _____ Carrier/Provider: _____