



BMA America 403(b)(9) Retirement Plan Salary Reduction Agreement

Use this form to direct your employer to defer part of your compensation to the BMA America Retirement Plan, or to change your existing Salary Reduction Agreement. Please give the completed form to your employer and retain a copy for your records. This form does not need to be returned to Ministers Resource Services or Envoy Financial.

1. Employee Information

Name First, Middle Initial, Last			Social Security Number	
Street Address				
City	State	Zip/Postal Code	Employer Name	

2. Salary Reduction Election

Subject to the requirements of the BMA America 403(b)(9) Retirement Plan of the above-named employer, I authorize the percentage or dollar amount listed below to be withheld from my pay each pay period and contributed to the BMA Retirement Plan as a salary reduction contribution.

Insert percentage	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th style="padding: 2px;">Percentage</th></tr> <tr><td style="text-align: center; padding: 2px;">%</td></tr> </table>	Percentage	%	OR	Insert single-sum amount	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th style="padding: 2px;">Amount</th></tr> <tr><td style="text-align: center; padding: 2px;">\$</td></tr> </table>	Amount	\$
Percentage								
%								
Amount								
\$								

_____ I do not want any deferrals withheld from my pay going forward and/or I elect to stop contributions as of

Day	Month	Year

3. Maximum Salary Reduction

I understand that the total amount of my salary reduction contribution in any calendar year cannot exceed the applicable amounts listed below.

Tax Year	Annual Deferral Amount < 50	Annual Deferral Amount 50 or Older*	Employee and Employer
2019	\$19,000	\$25,000	

* Employees age 50 or older by the end of the calendar year may make additional elective contributions annually.

4. Date Salary Reduction Begins

I understand that my salary reduction contributions will start as soon as permitted under the BMA Retirement Plan and as soon as administratively feasible. Or, if I prefer later, I choose the following date for my salary reductions to begin.

This date must be on or after the date you sign this Agreement.

Day	Month	Year

5. Duration of Election

By signing below, I understand this Salary Reduction Agreement replaces any earlier agreement and will remain in effect as long as I remain an Eligible Employee under the BMA Retirement Plan, until I provide my employer with a request to end my salary reduction contributions, or until I provide a new Salary Reduction Agreement as permitted under my employer's Retirement Plan.

Print Employee Name	
EMPLOYEE SIGNATURE	DATE