

457(b) Deferred Compensation Plan

Eligible Employee Deferral Agreement Change Form

Instructions

- A. The meaning of all capitalized terms used in this *Eligible Employee Deferral Agreement Change Form* shall have the same meaning as defined in the *457(b) Deferred Compensation Plan* (the "Plan").
- B. Contributions (i.e., *Employer Contributions* and *Employee Tax-sheltered Contributions*) to the Plan are subject to Contribution limits under the Internal Revenue Code. Contact the Compliance Department at GuideStone Financial Resources for more information.

1. PARTICIPANT INFORMATION

Participant name: _____ Social Security number (last four digits): _____

2. PARTICIPANT TAX-SHELTERED CONTRIBUTIONS

In accordance with the Plan, I elect the following:

I elect to change the amount of my Tax-sheltered Contributions to:

\$ _____ per pay period.

_____% of my compensation per pay period.

This election is effective the **1st day of** _____ (month, year). Subject to the Employer's right to terminate either the Plan or my future Plan participation, this election remains in effect for the taxable year and continues (*select one*):

for subsequent taxable years until I revoke or modify it.

until ____/____/____.

I elect to make a one-time Tax-sheltered Contribution of \$ _____ or _____% of my compensation effective the **1st day of** _____ (month, year).

I elect to cease my Tax-sheltered Contributions effective: ____/____/____.

3. PARTICIPANT SIGNATURE

- I understand that the administration of the above elections will be in accordance with the terms of the Plan.
- I understand that, except for an election to cease all Tax-sheltered Contributions, my election to defer compensation in Section 2 will only be effective no earlier than the first day of the month following my execution of this form.
- I understand that Employer Contribution amounts may change from time to time at the discretion of the Employer.
- I understand that **all Contributions** are subject to FICA (including Medicare) and FUTA at the time I perform services for the Employer. The Employer will deduct from my remaining compensation the above taxes on all Contributions to the Plan. Contributions and earnings are subject to income tax and income tax withholding when I actually or constructively receive the payment.
- I understand that all amounts credited to my account under the Plan are subject to the claims of general creditors of the Employer in the event of its bankruptcy or insolvency.

Participant signature: _____ Date: ____/____/____

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4. EMPLOYER SIGNATURE

Name of Employer: _____ Employer number: _____

Authorized officer: _____ Date: ____/____/____

5. BILLING INFORMATION (COMPLETED BY THE EMPLOYER)

Billing information:

A. Contribution period: *Bi-weekly *Semi-monthly Monthly One-time Other: _____

* Available for EAP billing only

B. Amounts per billing period:

Employer Contributions: \$ _____

Participant Contributions: \$ _____

Total billing amount: \$ _____