ABP-80-0082-0204

PO Box 295
Trenton, NJ 08625-0295

STATE OF NEW JERSEY
DIVISION OF PENSIONS AND BENEFITS

ALTERNATE BENEFIT PROGRAM
SALARY REDUCTION AGREEMENT

Name: _____
LAST FIRST MIDDLE

Social Security Number: _____ **ABP Number:** _____

Address: _____
STREET

_____
CITY STATE ZIP CODE

Daytime Telephone Number: (_____) – _____

The above named employee and the State of New Jersey agree that the employee's eligible earned base biweekly salary will be reduced by voluntary contributions beyond those required by the Alternate Benefit Program. The amount of reduction shall be _____% and will take effect on or after the first day of _____, 20___.* This reduction shall not exceed the employee's statutory exclusion allowance under Section 403(b) or the limitations of Section 415 of the Internal Revenue Code. The additional voluntary contributions will be allocated in the same manner and proportion as the mandatory contributions.

This agreement shall be legally binding as to each of the parties hereto while employment continues; provided that either party may terminate this agreement as of the end of any month, so that is will not apply to salary subsequently earned, by giving at least 30 days written notice of the date of termination; and provided further, that no more than one agreement for such salary reduction may be made within any taxable year.

Check one:

☐ Initial ☐ Subsequent

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____ _____
CERTIFYING OFFICER SIGNATURE TELEPHONE NUMBER DATE

**The requested change will be implemented approximately 30 days after receipt of this form by the Division of Pensions and Benefits.*

Mail completed form to: Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295