Arlington Public Schools Benefits Orientation

New Employees

and

Newly-Eligible Employees

Forms Packet

Arlington Public Schools

rev. January 2019

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Benefits Enrollment and Change Form for Active Employees *(please print)*

See Page 2 for Instructions and Important Information

1. Employee Last Name: _____ Employee First Name: _____ Middle Initial: _____

Employee #_____ Social Security Number: _____ Daytime Phone Number: _____

Date of Hire: _____ Work Location: _____ Effective Date of Coverage: ***(internal use only)*** _____

2. Life Event: ***(only select one)***

Attach supporting documentation to justify all Life Events. Coverage elections and changes are only allowed if requested within allowed timeframe (usually 31-days) per the list of Life Events.

- ◯ New Hire
- ◯ Marriage
- ◯ Divorce
- ◯ Birth or Adoption of Child
- ◯ Death of Spouse or Child
- ◯ Dependent Lost Eligibility Status
- ◯ Dependent Gains Eligibility Status
- ◯ Spouse/Dependent Gains other Coverage
- ◯ Spouse/Dependent Loses other Coverage
- ◯ Hours Increased
- ◯ Hours Decreased
- ◯ Unpaid Leave of Absence
- ◯ Open Enrollment
- ◯ Rehired
- ◯ Return from Unpaid Leave of Absence
- ◯ Other (list event below) _____

3.

Medical Coverage

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

SELECT ONE PLAN
- ◯ Kaiser Permanente HMO
- ◯ Cigna Open Access LOW Option
- ◯ Cigna Open Access HIGH Option

SELECT ONE COVERAGE
- ◯ Employee Only
- ◯ Employee + Spouse
- ◯ Employee + Child(ren)
- ◯ Family

Dental Coverage (with Delta Dental)

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

SELECT ONE COVERAGE
- ◯ Employee Only
- ◯ Employee + Spouse
- ◯ Employee + Child(ren)
- ◯ Family

Vision Coverage (with VSP)

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

SELECT ONE COVERAGE
- ◯ Employee Only
- ◯ Employee + Spouse
- ◯ Employee + Child(ren)
- ◯ Family

Voluntary Disability Buy-Up**

REQUEST
- ◯ Enroll
- ◯ Cancel
- ◯ Waive

**Employees enrolled in the Virginia Retirement System (VRS) Hybrid Plan are not eligible for the Disability Buy-Up coverage.

Flexible Spending Accounts

Flexible Spending Accounts, also known as FSAs, are funded 100% by the employee with pre-tax dollars. Go to www.apsva.us/benefits to learn more about the IRS rules that govern FSA plans.

Health Care FSA

*For eligible **health care expenses** incurred by you and your qualifying dependents.*

Plan Year: Your effective date of coverage through December 31st.

Maximum Annual Election: **$2,700** (2019 limit)

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ _____ Plan Year Election Amount

Dependent Care FSA

*For eligible **day care expenses** for qualifying child(ren) and qualifying adult dependents.*

Plan Year: Your effective date of coverage through December 31st.

Maximum Annual Election: **$5,000** (2019 limit)

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ _____ Plan Year Election Amount

Parking FSA

Your enrollment, cancellation, or deduction change will be effective the pay period following receipt of your enrollment or change request.

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ _____ Monthly Election Amount **$265 maximum** (2019 limit)

Transit FSA

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ _____ Monthly Election Amount **$265 maximum** (2019 limit)

4. Spouse / Dependent Information: ***(please print)***

If you are enrolling your eligible family members for benefits, you will need to provide the dependent's full name, date of birth, and Social Security number. If covering a spouse, you will need to provide a copy of your marriage certificate. If covering a dependent child, you will need to provide a copy of your child's birth certificate, or proof of adoption or legal guardianship.

Dependent's Social Security Number	Dependent's Name (Last, First, MI)	Relationship	Gender (M/F)	Dependent's Date of Birth	Medical (Yes / No)	Dental (Yes / No)	Vision (Yes / No)	Add / Drop

5. I hereby request enrollment and authorize deductions from my earnings of the required contributions for the above elected plan(s):

Employee Signature: _____ Date: _____

Return your completed form and applicable documents to the Human Resources Department.

APS Human Resources Department ◆ 2110 Washington Blvd., Arlington, VA 22204 ◆ Fax: 703-841-2138 ◆ E-Mail: benefits@apsva.us

TIP!

Go to www.apsva.us/benefits to view detailed benefit and coverage information.

APS Benefits Enrollment and Change Form

Instructions and Important Reminders:

Complete the "**APS Benefits Enrollment and Change Form**" indicating your coverage elections and/or waivers and return your completed form to the Human Resources Department. (*see contact information at bottom of form*)

Electing Medical, Dental, Vision, Voluntary Disability Buy-Up *(if eligible)*, Health Care FSA, and Dependent Care FSA

NEW Employee: Coverage will begin the on the 1st day of the month following 30-days of employment. You have 31-days from your first day of employment to elect coverage.

NEWLY-Eligible Employee: Coverage will begin on the 1st day of the month following the effective date of your new, benefits-eligible position. You have 31-days from your new, benefits-eligible position to elect coverage.

Electing Parking FSA and Transit FSA You can enroll or change your Parking and Transit FSA elections at any time during the year. Elections are effective the pay period following your election or change request.

Waiving Coverage If you decide not to enroll in coverage, you must complete the "**APS Benefits Enrollment and Change Form.**" Select the "Waive" boxes and return your completed form to Human Resources.

Electing Coverage for Eligible Dependents:

Your eligible dependents can also participate in the plans in which you are enrolled:

Your lawful spouse: your spouse is eligible to participate in the plan if he or she is an individual who is recognized as your husband or wife under the laws of the state where you live. *(Common-law spouses are not eligible.)*

If covering a spouse, you will need to provide a copy of your marriage certificate.

Your child(ren): including your biological child, legally-adopted child (or child placed for adoption), stepchild, foster child, child for whom you are the legal guardian and child you are required to cover under the terms of a qualified medical child support order, to age 26.

If covering a dependent child, you will need to provide a copy of your child's birth certificate, or proof of adoption or legal guardianship.

If you are enrolling your eligible family members for benefits, you will need to provide your dependent's full name, date of birth, gender, and Social Security number.

Enrollment Application for VRS Optional Group Life Insurance

VRS-39

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Richmond Branch Office • P.O. Box 1193 • Richmond, VA 23218-1193 • Phone 1-800-441-2258

Employer code (5 digits)	Employer name	Employee's annual salary
		$

1 - EMPLOYEE INFORMATION

Social Security number	Employee name (last, first, middle initial)

Street address	City	State	Zip code

Sex		Age	Date of birth (mo/day/yr)	Employment date (mo/day/yr)	Payroll frequency
☐ Male ☐ Female	☐ Married ☐ Single				

2 - ELECTION OF INSURANCE AMOUNTS

I wish to insure myself ☐ and ☐ my spouse and ☐ my child(ren).

Sign and date section 4, Payroll Deduction Authorization. (If you do not elect to be insured under the VRS Optional Plan you must complete section 5 below.)

	OPTIONAL INSURANCE AMOUNTS		
Option	Employee	Spouse	Child(ren)
☐ 1	1 X Salary	.5 X Salary	$ 10,000
☐ 2	2 X Salary	1.0 X Salary	$ 10,000
☐ 3	3 X Salary	1.5 X Salary	$ 20,000
☐ 4	4 X Salary	2.0 X Salary	$ 30,000

If the option you elected will provide insurance of $375,000 or higher, you must complete an Evidence of Insurability form (EOI). Your spouse must also complete an EOI form if you elected options 2,3, or 4. Optional amounts of insurance in excess of $750,000 for an employee and $375,000 for a spouse are not provided. If you and your spouse are insured as employees under the Basic VRS Group Life insurance plan neither of you is eligible for coverage as a spouse. If you do not apply when you are first eligible to do so, or within 31 days immediately thereafter, you must complete an EOI for yourself and eligible dependents you subsequently elect to insure.

3 - DEPENDENT INFORMATION

See reverse side for definition of Eligible Dependents (eligibility must be verified by Employer's Representative.)

How many children do you have who are less than 21 years of age? _____

How many children do you have who are age 21 to 25 and who are currently full-time students? _____

List information about your spouse and **youngest** child below:

Name (first name, middle initial, last)	Relationship	Sex	Social Security number	Date of Birth (mo/day/yr)
	Your Spouse	☐ Male ☐ Female		
	Youngest Child	☐ Male ☐ Female		

4 - PAYROLL DEDUCTION AUTHORIZATION

I hereby authorize my Employer to deduct from my compensation the amount necessary to provide the insurance amounts indicated above. I understand that the deduction amount will change as my age and annual salary change.

Signature	Date signed
X	

5 - WAIVER OF COVERAGE

I **DO NOT** wish to enroll for myself or for my eligible dependents in the VRS Optional Insurance Plan. I understand that once coverage is waived, I will have to furnish evidence of insurability for myself and eligible dependents if I wish to become insured at a later date.

Signature	Date signed
X	

6 - STATEMENT BY EMPLOYER'S REPRESENTATIVE

I certify that I believe the statements made herein are true and accurate, as disclosed by the records of this office, and the Social Security Number and Annual Salary are correct as entered.

Employer's representative	Title	Date signed
X		

ELIGIBLE DEPENDENTS

The following persons are eligible to be insured under the VRS Optional Group Life Insurance Plan:

- the employee's spouse, and
- the employee's unmarried, natural, or legally adopted children* who are not self-supporting, and
- the employee's unmarried step-children* who live full-time with the employee in a parent-child relationship and can be claimed as a dependent on the employee's Federal income tax return, and
- any other children* if they are in the permanent court-ordered custody of the employee.

* less than 21 years of age (age 25 if a full-time college student).

Beneficiary Information

The employee's beneficiary for Optional Group Life Insurance is the same as designated for the employee's Basic VRS Group Insurance. The employee is the beneficiary for the Optional Group Life Insurance on the employee's spouse and children.

How to Make Your Beneficiary Designations

Virginia Retirement System (VRS) Designation of Beneficiary

Form VRS-2 allows you to designate beneficiaries for your:

- Basic Life and Optional Life Insurance
- VRS Defined Benefit (pension) Member Account

YOUR ACTION:

Return your completed Designation of Beneficiary Form directly to the Virginia Retirement System (VRS). The contact information and mailing address for VRS are located at the top of the form. Make a copy of your form for your records. After you mail your form, contact VRS to ensure your beneficiary designations have been updated accordingly (please allow at least 30 days for updates to be made).

Designation of Beneficiary for VRS Hybrid Plan Members for Defined Contribution Plans

This form allows you to designate your beneficiaries for your:

- Hybrid 401(a) Cash Match Plan
- Hybrid 457 Deferred Compensation Plan

YOUR ACTION:

In addition to completing Form VRS-2 (mentioned above), VRS Hybrid Plan members should also complete a Designation of Beneficiary Form for the Defined Contribution Plans. Hybrid Plan members can fax their completed form, mail the original, or designate their beneficiaries online by creating an account at www.varetire.org/hybrid. Contact ICMA-RC in approximately 30-days to ensure your beneficiary designations have been updated accordingly. The contact information for ICMA-RC is located at the bottom of the form.

Optional Supplemental Retirements Plans (403b and 457 accounts)

YOUR ACTION:

After your account is established, contact the investment vendor to update your beneficiary designations:

- Lincoln Financial Group, call 1-800-234-3500
- AXA Advisors/PlanMember Services, call 1-800-874-6910

Arlington Public Schools

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DESIGNATION OF BENEFICIARY

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, Virginia 23218-2500
Toll Free 1-888-VARETIR (827-3847)
www.varetire.org

1. Social Security Number	
2. Employer Code	**40106 / 55506**

PART A. MEMBER/RETIREE INFORMATION

3. Name (First, Middle Initial, Last)	**4. Are you retired?** ❑ Yes ❑ No
5. Address (Street, City, State and Zip+4)	**6. Birth Date**

PART B. BENEFICIARIES FOR VRS BASIC AND OPTIONAL GROUP LIFE INSURANCE

Check ONE:

❑ **I revoke any previous designations and elect payment of VRS basic and optional group life insurance benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part C. (Order of precedence is explained in the form instructions.)

❑ **I revoke any previous designations and elect payment of VRS basic and optional group life insurance benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below.

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional beneficiaries for Part B listed on a VRS-2A continuation form?
❑ Yes ❑ No

PART C. BENEFICIARIES FOR VRS DEFINED BENEFIT MEMBER ACCOUNT RETIREMENT CONTRIBUTION/ BENEFITS

Check ONE:

- ❑ **I revoke any previous designations and elect payment of VRS defined benefit retirement contributions/benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part D. (Order of precedence is explained in the form instructions.)
- ❑ **I revoke any previous designations and elect payment of VRS defined benefit retirement contributions/benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below.

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional beneficiaries for Part C listed on a VRS-2A continuation form?
❑ Yes ❑ No

PART D. CERTIFICATION

Member Certification: I do hereby revoke all previous designations of primary and contingent beneficiaries, if any, and designate the beneficiary(ies) as indicated on this form to receive the proceeds of the basic and optional group life and accidental death and dismemberment insurance policies administered by VRS if I am covered under those policies, and to receive the accumulated retirement contributions/benefits to my credit in VRS at the time of my death. I do hereby direct that should I survive all of the above-named primary and contingent beneficiaries, any amount(s) which otherwise would have been payable to such beneficiary(ies) shall be paid in the order of precedence established by law and as listed in the instructions of this form or to such other beneficiary(ies) as I shall hereafter designate by written designation filed with the VRS Board of Trustees in accordance with its procedures. The right to change the beneficiary(ies) designation without the consent of said beneficiary(ies) is reserved. All information I provide in this document is true and I understand that any willful falsification of facts presented may result in prosecution as provided by law. (Persons holding a Power of Attorney, acting under a Guardianship, or acting as a Trustee may not make or change any beneficiary designation unless the relevant documentation specifically grants the authority to do so. Persons not holding such documents may not make or change any member's beneficiary designation unless granted the authority to do so by court order.)

Member Signature ______________________ Date ______________

7. Social Security Number:

INSTRUCTIONS FOR COMPLETING THE DESIGNATION OF BENEFICIARY

Complete this form to designate a beneficiary for VRS Basic and Optional Group Life Insurance and for your defined benefit retirement contribution account. It is only necessary to designate a beneficiary if you want payment to be made in a method other than by order of precedence established by law. If you previously completed a VRS-2 and wish to change beneficiaries or now wish to choose the order of precedence, you must complete this form to revoke any prior designations.

Please read the information provided on this form to understand your options for designating a beneficiary. Additional information is provided in your *Handbook for Members,* which is available on the VRS Web site (www.varetire.org) or from your human resources representative.

Order of Precedence: You may choose the order established by law to provide payment of your benefits or you may designate specific beneficiaries to receive your benefits in the event of your death. The order of precedence is as follows:

- To your spouse;
- *If no surviving spouse*, to your natural or legally adopted children and descendents of your deceased natural or legally adopted children;
- *If none of the above*, to your parents equally or to the surviving parent;
- *If none of the above*, to the duly appointed executor or administrator of your estate;
- *If none of the above*, to your next of kin under the laws of the state where you reside at the time of your death.

Life Insurance Benefits: Your VRS Basic and Optional Group Life Insurance benefits will be paid by order of precedence unless otherwise indicated in Part B of this form.

Defined Benefit Retirement Benefits

Death in Service:

If you are vested (have at least five years of service credit) and die while in service with a VRS-covered employer and your death is ***not*** work-related, VRS pays retirement benefits as follows:

- If no designation is made, or the death of all primary and contingent designated beneficiaries occurs prior to your death and another designation is not made, the beneficiary is determined by order of precedence.
- If you name your spouse, minor child(ren), or parent(s) as a beneficiary, or they are deemed the beneficiary by order of precedence, that person may receive a monthly benefit or may elect a refund of the contributions and accrued interest in your account to the exclusion of any other named beneficiary. The spouse will take precedence over a minor child, a minor child will take precedence over a parent.
- If the beneficiary named, or determined by order of precedence, is someone other than your spouse, minor child(ren), or parent(s), a refund of the contributions and interest credited to your account is paid.

If you are not vested and die while in service with a VRS-covered employer and your death is ***not*** work-related, VRS pays defined benefit retirement benefits in the form of a refund to your designated beneficiary.

If you die while in service with a VRS-covered employer, and your death ***is*** work-related, VRS pays defined benefit retirement benefits as follows regardless of whether or not you are vested:

- A refund of contributions and interest is paid to your designated beneficiary. If no designation is made, or the death of all of your primary and contingent designated beneficiaries occurs prior to your death and another beneficiary is not designated, the contributions and interest credited to your account are refunded to the beneficiary as determined by order of precedence.
- In addition to the refund of contributions and interest, a monthly benefit is paid to your surviving spouse for life. If you have no surviving spouse, the monthly benefit is paid to your minor child(ren) until age 18. If you have no minor child(ren), the benefit is paid to your parent(s) for life. All benefits are governed by and subject to the Virginia Retirement Act (Title 51.1 of the Code of Virginia.)

Death After Retirement:

If you die after your effective date of retirement and chose a payout option other than a Survivor Option, a refund of the contributions and interest that have not been paid to you as a monthly retirement benefit is refunded to your named beneficiary or, if no beneficiary designation is on file with VRS, to the first person qualifying by order of precedence.

If you die after your effective date of retirement and chose a Survivor Option, your monthly retirement benefit payment continues to the person you named as your contingent annuitant.

If you are retired, selected a survivor option and wish to change the name of the person you selected to receive the monthly benefit at the time of your death, contact VRS for further information. *This form cannot be used to change the contingent annuitant you designated at retirement*.

Death After Termination:

If you die after you have terminated your employment in a VRS-covered position but before beginning to receive a monthly retirement benefit and you have not taken a refund of the contributions and interest credited to your account prior to your death, a refund of the contributions and interest credited to your account is paid to your named beneficiary; or if no beneficiary designation is on file, to the first person qualifying by order of precedence.

Other Key Points to Remember

1. This form is *not* used to designate a beneficiary for any defined contribution account funds that you may have as a part of your covered employment. You must contact your defined contribution plan provider directly to designate beneficiaries.
2. This form cannot be used to designate a beneficiary for your spouse's or children's coverage under the Optional Life Insurance Plan because you are the beneficiary of those benefits.
3. If you name multiple primary beneficiaries, other than those established by law for death in service benefits, the proceeds will be split equally, unless you instruct otherwise in the Share % box for each beneficiary on this form. If you need to designate additional beneficiaries, list them on the Designation of Beneficiary – Continuation (VRS-2A) at the time you complete the VRS-2 and send both forms to VRS.
4. To be valid, this form must be filled out completely using given names such as "Mary L. Doe" rather than "Mrs. John Doe."
5. If a **minor** (child less than 18 years of age) is named as beneficiary, a guardian for the financial estate of the minor must be appointed by the court before benefits can be paid.
6. If an **estate** is named as beneficiary, a probated will appointing an administrator or executor must be provided or the court must appoint an administrator or an executor before benefits can be paid.
7. If a **trust** is named as beneficiary, list the name of the trustee and the date that the trust agreement was completed. Do not submit a copy of the trust with this form. A copy will be requested when the claim for benefits is made.
8. Forms that have been altered cannot be accepted. If you make an error when completing this form, either complete a new form or initial the information that was changed.
9. *Beneficiary Types:* When you choose beneficiaries, you must indicate whether each beneficiary is a primary or contingent beneficiary.

   Primary: Person(s) to receive the death benefits payable upon your death.

   Contingent: Person(s) to receive the death benefits payable upon your death, if the primary beneficiary(ies) dies before you.

9. *Share %:* You may provide less than 100% share to your beneficiaries. You may break down the shares designated in Part B different from those in Part C. Designations in Part B must total 100%, and designations in Part C must also total 100%.

Completing the Form

Part A. Member/Retiree Information

Enter your personal information in boxes 1 though 6, and box 7 on the 2nd page. Your VRS identification number must be clearly displayed in boxes 1 and 7. The employer code is required in box 2 only if you are an active VRS member.

Part B. Designation of Beneficiary for VRS Basic and Optional Group Life Insurance

Check the appropriate box to indicate whether you wish to have payment of basic and optional life insurance be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of life insurance to be paid to the person, and his or her birth date.

Part C. Designation of Beneficiary for Accumulated VRS Defined Benefit Retirement Contributions/Benefits

Check the appropriate box to indicate whether you wish to have payment of VRS retirement contributions/benefits be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of retirement contributions/benefits to be paid to the person, and his or her birth date.

Part D. Certification

Sign and date the member certification. Make a copy of the completed form for your records and mail the original to VRS.

DCP

Virginia Retirement System

DESIGNATION OF BENEFICIARY INSTRUCTIONS

HYBRID DEFINED CONTRIBUTION PLANS

Please provide all of the requested information for each designated beneficiary, including the date of birth and Social Security number, as this information will help ICMA-RC locate your beneficiaries.

The primary beneficiary(ies) will receive your Hybrid Retirement Plan Defined Contribution plan assets upon your death. You may designate one or more persons as your primary beneficiary(ies). If none of your primary beneficiaries are alive at the time of your death, then the assets will be paid to the contingent beneficiary(ies) that you have designated. You may designate one or more persons as your contingent beneficiary(ies). Be sure to use whole percentages when designating multiple beneficiaries. If you have not designated any beneficiaries or if both the Primary and Contingent Beneficiaries are not alive at the time of your death, then the assets will be paid pursuant to the terms of the Plan Document as follows: unless otherwise directed on the Beneficiary Designation form, the beneficiary designation shall be deemed to be my surviving spouse, or if none, my children and descendants of my deceased children, per stirpes, or if none, my parents equally if both living, or if none, the duly appointed executor or administrator of my estate, or if none, the next of kin entitled to inherit under the laws of my domicile at the time of my death, as determined by the Virginia Retirement Systems.

To designate additional beneficiaries, (1) write "see attached sheet" on the primary and/or contingent beneficiary line(s) under "Name" and (2) attach and sign a separate piece of paper with your name, plan number, Social Security number, and additional beneficiary information.

Missing percentage(s) for all of your primary and/or contingent beneficiaries will result in equal allocation among beneficiaries. Beneficiary designations are invalid if percentages are given for every beneficiary, but they do not equal 100% or are expressed with fractions (e.g., 33$^{1}/_{3}$%).

If you are naming a trust as your primary or contingent beneficiary, a complete copy of your entire trust document must be submitted with this form. ICMA-RC will not be able to honor your beneficiary designation if the entire copy of your trust document is not included.

SPOUSAL CONSENT FOR MARRIED PARTICIPANTS

If you live in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI), your spouse is generally entitled to be the primary beneficiary for at least 50% of your account unless he or she consents to waive this right in the presence of a notary public.

Failure to meet community property state law requirements with respect to your beneficiary designation may result in your beneficiary designation being invalid, and the payment of benefits to someone other than your intended beneficiary(ies).

AUTHORIZATION

Once you have completed this form, sign it and submit the pages to ICMA-RC. If this form is faxed (202-682-6439) to ICMA-RC, please do not mail the original.

Please be aware that designations made on this form only apply to the defined contribution component of the Hybrid Retirement Plan and do not impact designations you may make for the defined benefit component, which you must do separately. Some provisions related to voluntary contributions and the associated employer match may differ for school division employees who have elected to use an employer-sponsored hybrid 403(b). For additional information, contact your human resources office.

To designate a beneficiary(ies) for the defined benefit component, you may complete and submit a Designation of Beneficiary (VRS-2) to VRS. The form is available at www.varetire.org. Be sure to keep a copy for your records.

DCP

Virginia Retirement System

DESIGNATION OF BENEFICIARY FORM

HYBRID DEFINED CONTRIBUTION PLANS | 1 OF 3

108043 — Hybrid 401(a) Cash Match Plan

307059 — Hybrid 457 Deferred Compensation Plan

Date *(MM/DD/YYYY)*

__ __ / __ __ / __ __ __ __

NOTE: Beneficiary information can also be added, changed and deleted by accessing your account online at www.varetire.org or contacting an Investor Services associate at 1-VRS-DC-PLAN1 (1-877-327-5261).

PARTICIPANT INFORMATION — *PROVIDE NAME/SOCIAL SECURITY NUMBER AS IT CURRENTLY APPEARS ON YOUR ACCOUNT.*

Social Security Number

__ __ __ – __ __ – __ __ __ __

Email

_____

Full Name of Participant

_____ _____ _____

LAST *FIRST* *M.I.*

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. Primary and contingent beneficiaries must separately total 100%. The number of primary or contingent beneficiaries you may name is not limited. Attach an additional sheet if necessary. Please see instructions.

BENEFICIARY DESIGNATION

Read the important beneficiary information in the form instructions before completing this section. **Please use whole percentages and be sure the percentages total 100%** when designating primary and contingent beneficiaries.

HYBRID 401(A) CASH MATCH PLAN | 108043

A. Primary Beneficiary(ies) — will receive your assets upon your death. The primary beneficiary information you indicate here will supersede previously submitted information and will be used by ICMA-RC to determine the primary beneficiary(ies) entitled to all or a portion of your plan account.

PRIMARY BENEFICIAR(IES)

	Primary Beneficiary Name	Date of Birth *(MM/DD/YYYY)*	Relationship to You*	Social Security Number	% of Benefit
1		__ __/__ __/__ __ __ __		__ __ __ – __ __ – __ __ __ __	%
2		__ __/__ __/__ __ __ __		__ __ __ – __ __ – __ __ __ __	%
3		__ __/__ __/__ __ __ __		__ __ __ – __ __ – __ __ __ __	%

**The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.*

Total = 100%

B. Contingent Beneficiary(ies) — will receive your assets if there is no primary beneficiary(ies) living at the time of your death. The contingent beneficiary information you indicate here will supersede previously submitted information and will be used by ICMA-RC to determine the contingent beneficiary(ies) entitled to all or a portion of your plan account.

CONTINGENT BENEFICIAR(IES)

	Contingent Beneficiary Name	Date of Birth *(MM/DD/YYYY)*	Relationship to You*	Social Security Number	% of Benefit
1		__ __/__ __/__ __ __ __		__ __ __ – __ __ – __ __ __ __	%
2		__ __/__ __/__ __ __ __		__ __ __ – __ __ – __ __ __ __	%
3		__ __/__ __/__ __ __ __		__ __ __ – __ __ – __ __ __ __	%

**The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.*

Total = 100%

Plan Number	Social Security Number	Name *(Last, First, M.I.)*	Date *(mm/dd/yyyy)*
108043 | 307059	__ __ __ – __ __ – __ __ __ __		__ __ / __ __ / __ __ __ __

BENEFICIARY DESIGNATION (CONTINUED)

HYBRID 457 DEFERRED COMPENSATION PLAN | 307059

☐ *PLEASE CHECK HERE IF YOU WOULD LIKE TO DESIGNATE THE SAME PRIMARY AND CONTINGENT BENEFICIARIES THAT YOU LISTED ON PAGE 1 — YOU DO NOT NEED TO COMPLETE THIS SECTION.*

A. Primary Beneficiary(ies) — will receive your assets upon your death. The primary beneficiary information you indicate here will supersede previously submitted information and will be used by ICMA-RC to determine the primary beneficiary(ies) entitled to all or a portion of your plan account.

PRIMARY BENEFICIAR(IES)

	Primary Beneficiary Name	Date of Birth *(mm/dd/yyyy)*	Relationship to You*	Social Security Number	% of Benefit
1		__ __ / __ __ / __ __ __ __		__ __ __ – __ __ – __ __ __ __	%
2		__ __ / __ __ / __ __ __ __		__ __ __ – __ __ – __ __ __ __	%
3		__ __ / __ __ / __ __ __ __		__ __ __ – __ __ – __ __ __ __	%

The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.* **Total = 100%

B. Contingent Beneficiary(ies) — will receive your assets if there is no primary beneficiary(ies) living at the time of your death. The contingent beneficiary information you indicate here will supersede previously submitted information and will be used by ICMA-RC to determine the contingent beneficiary(ies) entitled to all or a portion of your plan account.

CONTINGENT BENEFICIAR(IES)

	Contingent Beneficiary Name	Date of Birth *(mm/dd/yyyy)*	Relationship to You*	Social Security Number	% of Benefit
1		__ __ / __ __ / __ __ __ __		__ __ __ – __ __ – __ __ __ __	%
2		__ __ / __ __ / __ __ __ __		__ __ __ – __ __ – __ __ __ __	%
3		__ __ / __ __ / __ __ __ __		__ __ __ – __ __ – __ __ __ __	%

The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.* **Total = 100%

SPOUSAL CONSENT — *ONLY APPLICABLE TO PARTICIPANTS RESIDING IN AZ, CA, ID, NV, NM, TX, WA, OR WI*

IF YOU LIVE IN THE COMMONWEALTH OF VIRGINIA, THIS SECTION IS NOT APPLICABLE.

Spousal Consent to Name a Non-Spousal Primary Beneficiary(ies): By signing below, I hereby voluntarily consent to the beneficiary designation made by my spouse and waive my designation as sole primary beneficiary. I understand that (1) the effect of this designation is to cause some or all of my spouse's death benefit to be paid to someone other than me; (2) each beneficiary designation is not valid unless I consent to it; and (3) my consent (signature) must be witnessed by a notary public.

Signature of Participant's Spouse _____ Date __ __ / __ __ / __ __ __ __

Print Name of Participant's Spouse _____

Your request cannot be processed without a Notary Public Signature and Seal.

SPOUSAL CONSENT IS REQUIRED TO BE WITNESSED BY:

Notary Public

Subscribed and sworn before me this _____ day of _____ *(month)*, 20 __ __

Notary Signature _____

Commission Expiration Date __ __ / __ __ / __ __ __ __

Registration Number: _____

Seal Or Stamp

Plan Number	Social Security Number	Name *(Last, First, M.I.)*	Date *(mm/dd/yyyy)*
108043 | 307059	__ __ __ – __ __ – __ __ __ __	_____	__ __/__ __/__ __ __ __

REQUIRED PARTICIPANT SIGNATURE

This designation is effective when signed, dated and received by ICMA-RC ("Service Provider") at the address below prior to the death of the participant. If I name more than one beneficiary in either category, the surviving beneficiaries in that category will share equally unless otherwise indicated. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document as follows: unless otherwise directed on the Beneficiary Designation form, the beneficiary designation shall be deemed to be my surviving spouse, or if none, my children and descendants of my deceased children, per stirpes, or if none, my parents equally if both living, or if none, the duly appointed executor or administrator of my estate, or if none, the next of kin entitled to inherit under the laws of my domicile at the time of my death, as determined by the Virginia Retirement Systems.

I have completed, understand and agree to all pages of this Beneficiary Designation form. I understand that the Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, the Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: http://www.ustreas.gov/offices/eotffc/ofac.

Participant Signature _____ Date __ __/__ __/__ __ __ __

SEND ORIGINAL TO ICMA-RC:

ICMA-RC
Attn: Workflow Management Team
P.O. Box 96220
Washington, DC 20090-6220

Fax Number: **202-682-6439**

Website: www.varetire.org

Arlington Public Schools, VA

Salary Reduction Agreement for 403(b) and/or ROTH 403(b) Annuity Contract or 403(b)(7) Custodial Account

Please Print or Type Legibly

1

Employee Name

Employee Email Address | **Work Location**

Mailing Address

Number of Payrolls Per Year: ☐ 24 ☐ 20

2

Employee I.D. Number

- OR -

Employee Social Security Number

3 ☐ **Original Agreement or** ☐ **Amendment to a Previous Agreement**

4 **Reduction Amount**

List all companies and salary reductions requested whether new or existing.
IMPORTANT: Read instructions on page 2 of this form.

If effective payroll date is blank, changes will take effect the next processing period after receipt of this from by TSACG.

COMPANY NAME	PROVIDER CODE (See Page 2 for Code)	Designates 403(b)	Designates ROTH 403(b)	SALARY REDUCTION DOLLAR AMOUNT (Per Pay Period)	EFFECTIVE PAYROLL DATE (New account or amendment - MM/DD/YY)	Terminate Reduction
		☐	☐	, .	/ /	☐
		☐	☐	, .	/ /	☐

The total amount of contributions to all providers , . **for each pay period.**

NOTICE: Any SRA accounts not listed will be automatically terminated.

5

Election:

☐ I am opting out of this program.

☐ Yes, I choose to participate in this program. Deductions from my paycheck will begin on the next available paycheck or as of the date I indicated in the "Effective Payroll Date." ("Effective Payroll Date" cannot be more than 90 days from my signature date.) If I want to change my deductions, or select a financial advisor to help me invest for retirement, I understand I must select an investment product provider from the APS authorized provider listing (on page 2 of this form) and complete and submit the appropriate forms according to the procedures of the plan.

School Board Match Program:
APS will match, on a per pay check basis, your contribution to an APS-sponsored 403(b), ROTH 403(b), 457(b) or ROTH 457(b) account up to the limit determined by APS. Employees are only eligible for one School Board Match contribution. The School Board matches up to 0.4% of your base salary, **or** up to $240 per year (up to $10/pay period for 24-pay employees, or up to $12/pay period for 20-pay employees), **whichever is greater.** School Board Match contributions are made as Employer Contributions in your name into a 403(b) account to whichever vendor you have chosen for your 403(b) or 457(b) account.

More Information:
Go to www.apsva.us/benefits/supplementalretirement/ for more information about your Supplemental Retirement Plan options and the School Board Match Program.

The amount elected above shall result in a total ANNUAL REDUCTION not to exceed the maximum allowable contribution calculation as stated below. The Employer agrees that it will remit the amount of such reduction and/or change for the 403(b) and/or ROTH 403(b) Tax Sheltered Annuity or 403(b)(7) custodial account offered by the Company (companies) listed above. I realize that if the change results in decrease or elimination of reduction under the 403(b) T.S.A. program, that this reduction or elimination cannot be "made up" in the future unless it falls within the allowable limit for that calendar year.
This Agreement shall be legally binding and irrevocable with respect to amounts earned while the Agreement is in effect, and any termination of this Agreement shall be effective only with respect to amounts not yet earned at the time of said termination. This reduction may not exceed the employee's statutory limit per Section 403(b), Section 402(g) or Section 415 of the Internal Revenue Code, that limits the total allowable salary reduction to all Companies to which salary reduction contributions can be made.
I hereby authorize my Employer to reduce or suspend any contributions established by this agreement if in its opinion the total annual contributions would exceed my Maximum Allowable Contribution in any calendar year.
For 403(b)- The Employee is responsible for the accuracy of the excludable amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary reduction in this agreement, or any other violation of the requirement of Section 403(b) could result in additional taxes, interests, and penalties to the Employee.

For 403(b) ROTH- The Employee is responsible for the accuracy of the amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary deduction in this agreement, or any other violation of the requirement of Section 403(b) could result in additional taxes, interests, and penalties to the Employee.
It is the intent of the parties that the non-forfeitable retirement deferred annuity or custodial contract pursuant to this Agreement shall qualify for the federal income tax benefits provided for in Section 403(b) of the Internal Revenue Code. Any change to this Agreement must be in writing to the Employer and becomes effective upon the execution of this Agreement by Employee and Employer. This Agreement may be terminated by either the Employer or Employee upon notice to the Employer or Employee as applicable. This Agreement is processed by TSA Consulting Group, Inc., as the Administrator by Contract for Arlington Public Schools' 403(b)/403(b)(7) plan administrator services provider.

6

AGENT REPRESENTATIVE (IF APPLICABLE) PLEASE PRINT NAME

AGENT PHONE

7

EMPLOYEE TELEPHONE NUMBER

I agree with the terms above:

EMPLOYEE SIGNATURE

DATE OF THIS AGREEMENT

SRA is not valid if "Effective payroll Date" in Section 4 is more than 90 days from the "Date of this Agreement" in Section 7.

8

Mail, Email or Fax forms to:

TSA Administration Services
Attn: SRA Processing Dept.
P.O. Box 4037
Fort Walton Beach, FL 32549

Email: SRAprocessing@tsacg.com

Fax: 1-866-908-7582

Employee Instructions:
1. Complete the Employee sections regarding “Name,” “Email Address,” “Mailing Address” and “Work Location.” Select the number of payrolls that you, the employee, receive during a calendar year.
2. Enter your “I.D. Number” and/or “Social Security Number” in the boxes provided.
3. Mark the box that corresponds with the type of SRA your are submitting: “Original Agreement” or “Amendment to a Previous Agreement.”
4. (a) Enter the info for ALL your new and/or existing accounts (you may have only one account or multiple accounts).
   NOTICE: Any SRA accounts not listed will be automatically terminated.
   (b) In addition to entering the company name, the employee and/or agent MUST fill in the correct Provider Code on the SRA (list available with this SRA or online at http://www.tsacg.com/individual/plan-sponsor/virginia/arlington-public-schools/
   (c) Enter the salary reduction amount (dollar amount) you wish to be withheld from your payroll.
   (d) If this SRA is being submitted to terminate a current salary reduction, please list the company name to be terminated and indicate “Terminate Reduction” in the space provided (check box).
   (e) Total the dollar amount for all contributions, and enter the total in the box provided.
5. Complete this section for “Automatic Enrollment” (New hires).
6. Provide agent name and telephone number, if applicable.
7. Sign and date the agreement. Please provide a telephone number where you can be reached during business hours.
8. Mail the completed original signed agreement to TSA Administration Services, Attn: SRA Processing Dept., P.O. Box 4037, Fort Walton Beach, FL 32549 or fax the completed form to 1-866-908-7582 or e-mail to sraprocessing@tsacg.com

The employer, Arlington Public Schools, will apply and remit the salary reduction documented on page 1 of this SRA form to TSA Consulting Group, Inc. The administrator is providing remittance and administration services for voluntary retirement plans for Arlington Public Schools.

PRIVACY - The administrator shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the plan.
The administrator shall disclose information described only:
(a) in response to a court order;
(b) for an examination conducted by the commissioner of insurance;
(c) for an IRS audit or investigation;
(d) to or at the request of the insurer or plan sponsor; or
(e) with the written consent of the identified individual or his or her legal representative.

Authorized 403(b) Providers (as of July 01, 2015)

AXA Advisors / PlanMember Services (provider code = AX)

Local Vendor Representatives:

Mark Toia
Phone: (703) 207-0900
Email: Mark.Toia@Axa-Advisors.com

Main Office - (800) 874-6910
www.Planmember.com/aps

Lincoln Financial Group (provider code = LI)

Local Vendor Representatives:

Michael Knapp
Phone: (571) 438-1705
Email: Michael.Knapp@LFG.com

Liliana Zarate (Spanish speaking)
Phone: (202) 329-5715
Email:Liliana.Zarate@LFG.com

Main Office - (800) 234-3500
www.LFG.com/aps

SRA SUBMISSION DEADLINE	FOR PAYROLL DATE
09/19/2018	09/28/2018
10/03/2018	10/15/2018
10/19/2018	10/31/2018
11/02/2018	11/15/2018
11/19/2018	11/30/2018
12/04/2018	12/14/2018
12/17/2018	12/31/2018
01/04/2019	01/15/2019
01/17/2019	01/31/2019
02/05/2019	02/15/2019
02/19/2019	02/28/2019
03/05/2019	03/15/2019
03/20/2019	03/29/2019
04/03/2019	04/15/2019
04/15/2019	04/30/2019
05/03/2019	05/15/2019
05/20/2019	05/31/2019
06/04/2019	06/14/2019
06/19/2019	06/28/2019
07/02/2019	07/15/2019

Arlington Public Schools, VA

Participation Agreement for Internal Revenue Code Section 457(b) and/or ROTH 457(b) Deferred Compensation Program

Please Print or Type Legibly

1 Employee Name

Employee Email Address | Work Location

Mailing Address

Number of Payrolls Per Year: ☐ 24 ☐ 20

2 Employee I.D. Number

- OR -

Employee Social Security Number

3 ☐ Original Agreement or ☐ Amendment to a Previous Agreement

4 **Reduction Amount**

List all companies and salary reductions requested whether new or existing.
IMPORTANT: Read instructions on page 2 of this form.

If effective payroll date is blank, changes will take effect the next processing period after receipt of this from by TSACG.

COMPANY NAME	PROVIDER CODE (See Page 2 for Code)	Designates 457(b)	Designates ROTH 457(b)	SALARY REDUCTION DOLLAR AMOUNT (Per Pay Period)	EFFECTIVE PAYROLL DATE (New account or amendment - MM/DD/YY)	Terminate Reduction
		☐	☐	, .	/ /	☐
		☐	☐	, .	/ /	☐
The total amount of contributions to all providers				, .	**for each pay period.**	

NOTICE: Any SRA accounts not listed will be automatically terminated.

5 Election:

☐ I am opting out of this program.

☐ Yes, I choose to participate in this program. Deductions from my paycheck will begin on the next available paycheck or as of the date I indicated in the "Effective Payroll Date." ("Effective Payroll Date" cannot be more than 90 days from my signature date.) If I want to change my deductions, or select a financial advisor to help me invest for retirement, I understand I must select an investment product provider from the APS authorized provider listing (on page 2 of this form) and complete and submit the appropriate forms according to the procedures of the plan.

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APS will match, on a per pay check basis, your contribution to an APS-sponsored 403(b), ROTH 403(b), 457(b) or ROTH 457(b) account up to the limit determined by APS. Employees are only eligible for one School Board Match contribution. The School Board matches up to 0.4% of your base salary, **or** up to $240 per year (up to $10/pay period for 24-pay employees, or up to $12/pay period for 20-pay employees), **whichever is greater.** School Board Match contributions are made as Employer Contributions in your name into a 403(b) account to whichever vendor you have chosen for your 403(b) or 457(b) account.

More Information:
Go to www.apsva.us/benefits/supplementalretirement/ for more information about your Supplemental Retirement Plan options and the School Board Match Program.

Important Reminder for Virginia Retirement System (VRS) Hybrid Plan Participants: As a Hybrid Plan Participant, you are eligible to make voluntary employee contributions to a VRS Hybrid 457 Deferred Compensation plan in addition to voluntary employee contributions to an APS-sponsored 457(b) Deferred Compensation plan. If you make contributions to both the VRS Hybrid 457 Deferred Compensation plan and an APS-sponsored 457(b) Deferred Compensation plan, *your total contribution amount to both plans must not exceed IRS annual contribution limits*. The 2019 457 Basic Contribution limit is $19,000. Additional Age-Based Catch Up Amounts and Service-Based Catch Up Amounts may also apply.

The undersigned hereby agrees to the terms and conditions of the Arlington Public Schools, VA Deferred Compensation Plan ("Plan") as such Plan now exists or is hereinafter amended and a copy of the Plan has been made available to them. This election shall continue until the undersigned makes a subsequent election as provided by the Plan.
I (the Employee) understand and agree to the following: My deferrals cannot begin sooner than the month following Participation Agreement approval. My accumulated deferrals will be held in trust for the exclusive benefit of participants and their beneficiaries until paid to me under the rules of the Plan. I realize I may not assign or transfer my rights under the Plan.
For 457- I am responsible for the accuracy of the excludable amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary reduction in this agreement, or any other violation of the requirements of IRS Code Section 457 could result in additional taxes, interest, and penalties to the Employee.For 457 ROTH- I am responsible for the accuracy of the amounts stated in this Agreement. Any overstatement of the amounts excludable as a salary deduction in this agreement, or any other violation of the requirements of IRS Code Section 457 could result in additional taxes, interest, and penalties to the Employee. I hereby authorize my Employer to reduce or suspend any deferrals established by this agreement, if in its opinion, the total annual deferral would exceed the maximum allowable limit in any calendar year. Should my deferral exceed the maximum limit, I authorize my Employer to disallow deferral of the excess amount and direct these amounts to be refunded to me.
Release of Liability - The Employee agrees that the Employer and its agents shall have no liability whatsoever for any and all losses suffered by me with regard to my selection of the annuity and/or custodial account, its terms, the selection of the insurance company, custodian, or regulated investment company, the financial condition, operation of or benefits provided by said insurance company, custodian, or regulated investment company, or my selection and purchase of shares of regulated investment companies.
The employer hereby authorizes on the provider company to issue a annuity contract or custodial arrangement for the benefit of the participant without the signature of the employer provided that the owner of the annuity contract or custodial arrangement is designated as the employer's 457 Deferred Compensation Plan.
Earnings, if any, will be applied to my accumulated deferrals in accordance with the Company and product I have selected. Neither the Employer, nor Trustees, nor agencies of the Employer shall be liable for the performance of the Companies or products selected by the Employee. Any change to this Agreement must be in writing to the Employer and becomes effective upon the execution of this Agreement by Employee and Employer. This Agreement may be terminated by either the Employer or Employee upon thirty (30) days notice to the Company and to the Employer or Employee as applicable.
Designation of Beneficiary - The beneficiary for each annuity contract or certified account to which contributions are allocated shall be determined in accordance with the terms of that specific contract or account.

6

AGENT REPRESENTATIVE (IF APPLICABLE)
PLEASE PRINT NAME

AGENT PHONE

7

EMPLOYEE TELEPHONE NUMBER

I agree with the terms above:

EMPLOYEE SIGNATURE

DATE OF THIS AGREEMENT

SRA is not valid if "Effective payroll Date" in Section 4 is more than 90 days from the "Date of this Agreement" in Section 7.

8

Mail, Email or Fax forms to:

TSA Administration Services
Attn: SRA Processing Dept.
P.O. Box 4037
Fort Walton Beach, FL 32549

Email: SRAprocessing@tsacg.com

Fax: 1-866-908-7582

Employee Instructions:
1. Complete the Employee sections regarding “Name,” “Email Address,” “Mailing Address” and “Work Location.” Select the number of payrolls that you, the employee, receive during a calendar year.
2.Enter your “I.D. Number” and/or “Social Security Number” in the boxes provided.
3.Mark the box that corresponds with the type of SRA your are submitting: “Original Agreement” or “Amendment to a Previous Agreement.”
4. (a) Enter the info for ALL your new and/or existing accounts (you may have only one account or multiple accounts).
NOTICE: Any SRA accounts not listed will be automatically terminated.
(b) In addition to entering the company name, the employee and/or agent MUST fill in the correct Provider Code on the SRA (list available with this SRA or online at http://www.tsacg.com/individual/plan-sponsor/virginia/arlington-public-schools/
(c) Enter the salary reduction amount (dollar amount) you wish to be withheld from your payroll.
(d) If this SRA is being submitted to terminate a current salary reduction, please list the company name to be terminated and indicate “Terminate Reduction” in the space provided (check box).
(e) Total the dollar amount for all contributions, and enter the total in the box provided.
5.Complete this section for “Automatic Enrollment” (New hires).
6. Provide agent name and telephone number, if applicable.
7. Sign and date the agreement. Please provide a telephone number where you can be reached during business hours.
8.Mail the completed original signed agreement to TSA Administration Services, Attn: SRA Processing Dept., P.O. Box 4037, Fort Walton Beach, FL 32549 or fax the completed form to 1-866-908-7582 or e-mail to sraprocessing@tsacg.com

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The administrator shall disclose information described only:
(a) in response to a court order;
(b) for an examination conducted by the commissioner of insurance;
(c) for an IRS audit or investigation;
(d) to or at the request of the insurer or plan sponsor; or
(e) with the written consent of the identified individual or his or her legal representative.

Authorized 457(b) Providers (as of July 01, 2015)

AXA Advisors / PlanMember Services (provider code = AX)

Local Vendor Representatives:

Mark Toia - (703) 207-0900
Email: Mark.Toia@Axa-Advisors.com

Main Office - (800) 874-6910
www.Planmember.com/aps

Lincoln Financial Group (provider code = LI)

Local Vendor Representatives:

Michael Knapp - (571) 438-1705
Email: Michael.Knapp@LFG.com

Liliana Zarate (Spanish speaking) - (202) 329-5715
Email: Liliana.Zarate@LFG.com

Main Office - (800) 234-3500
www.LFG.com/aps

Note: The agreement to defer compensation must be entered into before the first day of the month in which the deferrals are to begin. The schedule below applies to deferral changes and deferral terminations.

SRA SUBMISSION DEADLINE	FOR PAYROLL DATE
09/19/2018	09/28/2018
10/03/2018	10/15/2018
10/19/2018	10/31/2018
11/02/2018	11/15/2018
11/19/2018	11/30/2018
12/04/2018	12/14/2018
12/17/2018	12/31/2018
01/04/2019	01/15/2019
01/17/2019	01/31/2019
02/05/2019	02/15/2019
02/19/2019	02/28/2019
03/05/2019	03/15/2019
03/20/2019	03/29/2019
04/03/2019	04/15/2019
04/15/2019	04/30/2019
05/03/2019	05/15/2019
05/20/2019	05/31/2019
06/04/2019	06/14/2019
06/19/2019	06/28/2019
07/02/2019	07/15/2019

Arlington Public Schools, VA
Participation Agreement for Internal Revenue Code Section 457(b) and/or ROTH 457(b) Deferred Compensation Program