DIVERSIFIED INVESTMENT ADVISORS
4333 Edgewood Road NE, Cedar Rapids, IA 52499
800-394-5240
http://retirementprogram.trinity-health.org

TRINITY HEALTH
Novi, Michigan

Salary Reduction Agreement

Instructions

Please complete the information below *and return this form to your employer.*

☐ Initial Agreement

☐ Agreement Change *(modifies any prior agreement)*

SECTION A. Employer Information

Company/Employer Name

Contract/Account No. **T T 0 8 0 1 8 1**

Affiliate No.

Division No.

SECTION B. Employee Information

Social Security No. ___ – ___ – ____

Employee Number, if applicable

Department

Last Name

First Name/Middle Initial

Street Address/Apt. No.

Phone No. ___ – ___ – ____

Ext. (if any)

City

State

Zip Code ____ – ____

Marital Status
☐ Married ☐ Single/Divorced

SECTION C. Salary Reduction Agreement

☐ I agree to reduce my eligible compensation by $_____ (amount) or _____ (whole percentages)% each pay period as an after-tax contribution.

The above authorization is effective with the payroll period beginning _____ (date) *(may not be retroactive)*.

SECTION D. Signature

I understand that I may change the amount of my salary reduction, or terminate this agreement, by giving notice in accordance with the terms of my employer's plan/program.

X _____ _____
Employee Signature Date