



State University of New York  
Upstate Medical University

Salary Reduction  
Agreement

rev. Jan 2005

Name	ID Number	(Circle One): CSEA PEF UUP M/C	Daytime Telephone No.
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By THIS AGREEMENT, made between \_\_\_\_\_, an employee of the State University of New York  
(Your Name)  
(employer), the parties hereto agree as follows:

Effective with respect to amounts paid on or after \_\_\_\_\_, which date is subsequent to the execution  
(Effective Date)  
of this agreement, or as soon as possible thereafter, the employee's salary will be reduced by the amount indicated below.

The employer will contribute that amount to the employee's account with (please check):

- TIAA-CREF
- Fidelity (limited to UUP represented and M/C designated employees)
- Circle: ING MetLife VALIC (This option is available only to UUP represented employees)

\_\_\_\_\_  
(Name of Representative) (Telephone #)

The amount of the salary reduction will be \$\_\_\_\_\_ per bi-weekly payroll period. This amount, together with any amounts previously contributed this year, must produce a total contribution that does not exceed the employee's statutory allowance under IRC Section 403(b), or the limitations of IRC Section 415 or Section 402(g), whichever is least. The responsibility for assuring that the salary reduction amount listed above, as well as any other salary reductions with the same or another employer, does not exceed the maximum exclusion allowance defined in the Internal Revenue Code rests with the employee.

This Agreement shall be legally binding and irrevocable as to each of the parties hereto while employment continues. However, either party may terminate or modify this agreement as of the end of any payroll period by giving at least 30 days written notice, so that this agreement will not apply to salary subsequently paid.

Are you currently making elective deferrals (i.e., pre-tax contributions) under any other retirement plan not noted above?   
Yes  No If Yes, please list the names of the plan(s): \_\_\_\_\_

\_\_\_\_\_  
(Employee Signature) (Date)

\_\_\_\_\_  
(Human Resources Benefits Office) (Date)

**- For Office Use Only -**

Plan Type (circle):  
TDA (405) SRA (404) UUP (415) Fidelity (408)

First Check: \_\_\_\_\_

Change Goal Amount to: \$\_\_\_\_\_