ABP-80-0082-0320

State of New Jersey • Department of the Treasury
DIVISION OF PENSIONS & BENEFITS — DEFINED BENEFIT & DEFINED CONTRIBUTION BUREAU
P.O. Box 295, Trenton, NJ 08625-0295

ALTERNATE BENEFITS PROGRAM (ABP) – SALARY REDUCTION AGREEMENT

Name _____
Last *First* *Middle*

Social Security Number _____ ABP Number _____

Address _____
Street *City* *State* *Zip Code*

Phone Number _____

The above named employee and the State of New Jersey agree that the employee's eligible earned base bi-weekly salary will be reduced by voluntary contributions beyond those required by the Alternate Benefit Program (ABP). The amount of reduction shall be _____ percent 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 it 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.

I request a(n) ☐ Initial Reduction ☐ Subsequent Reduction

_____ _____/_____/_____
Employee Signature *Date*

_____ _____ _____/_____/_____
Print Certifying Officer Name *Signature* *Date*

_____
Certifying Officer Phone Number

Note: The requested change will be implemented approximately 30 days after receipt of this form by the New Jersey Division of Pensions & Benefits.

Mail the completed form to: **New Jersey Division of Pensions & Benefits**
Alternate Benefits Program
P.O. Box 295
Trenton, NJ 08625-0295