SALARY REDUCTION AGREEMENT

EFFECTIVE PAY PERIOD BEGIN DATE: ________________________________

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>Region: BHIP, BHCS, BHC, BHMC, BHN</th>
<th>Hire Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee No.:</td>
<td>Region: BHIP, BHCS, BHC, BHMC, BHN</td>
<td>Hire Date:</td>
</tr>
<tr>
<td>Status Code:</td>
<td>Daytime Phone No.:</td>
<td>If Rehired, previous employment dates:</td>
</tr>
</tbody>
</table>

☐ Investment Company Change  ☐ % Reallocation Only

☐ I authorize Broward Health to make the following changes in my earnings:

Employee contributions may not exceed the IRS annual limitation
Employee and employer contributions are based on the IRS maximum compensation limit

☐ Enroll me in the STAR PLUS Plan. I elect to contribute ______% each pay period.
Account application has been submitted to vendor: (circle one) YES or NO. If yes, ____________ date submitted

☐ Change my current STAR PLUS contributions to ______% each pay period (sum of breakdown below).

☐ STOP all Star Plus salary contributions.

I. MATCHED CONTRIBUTIONS (First 1% matched at 100%, next 4% matched at 35%)

Circle One Vendor: Fidelity Valic

II. UNMATCHED CONTRIBUTIONS (Indicate % under Vendor[s] of your choice)

Fidelity Valic

Total Unmatched ______% ______%

III. UNMATCHED CATCH-UP CONTRIBUTIONS (Check all that apply - include $ when calculating total % above)

☐ age 50 and over

☐ 15 years of service / up to $3000 per year to lifetime cap of $15,000

Employee Signature: ________________________________ Date Signed: ________________________________

Star Plus Vendor Signature: ________________________________

FOR BENEFITS OFFICE USE ONLY:

Keyed by: ________________________________ Keyed date: ________________________________

Benefits Rep. initials

COPY DISTRIBUTION: ORIGINAL Forward to District Benefits

E-mail: benefits@browardhealth.org FAX: 954-888-3686