SALARY REDUCTION AGREEMENT

STAR PLUS
Saving Toward Affordable Retirement

EFFECTIVE PAY PERIOD BEGIN DATE: _____

Employee Name:		
Employee No.:	Region: BHIP, BHCS, BHC, BHMC, BHN	Hire Date:
Status Code:	Daytime Phone No.:	If Rehired, previous employment dates:

☐ **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