



The completion and submission of this questionnaire will serve as notice of intent to have AFPlanServ® provide administrative services for your 403(b) Plan. Please answer all questions and submit all information requested. The responses to these questions will be reflected in the written Plan and the Administrative Services that will be established for your Plan.

Employer Information

Legal Name of Employer: _____

Federal Tax ID #: _____

Employer Address: _____

Employer Phone Number: _____

Employer Fax Number: _____

Employer E-Mail Address: _____

Employer Contact Person: _____

Contact Phone Number (including extension): _____

Contact E-Mail Address (if different than Employer): _____

Type of Organization:

K-12 Public School Vocational/Technical College/University Other:

If other, please specify: _____

Classification: Public Private

Related Employer(s): (specify) _____

Plan Information

Name of Plan: _____ 403(b) Plan

Written Plan Status:

New (Initial 403(b) Plan established by the Employer) Requested Effective Date: _____

Amendment of Existing 403(b) Plan Original Plan Effective Date: _____

Plan Entry Dates:

Anytime during the Plan year.

Other: _____

Plan Year:

Calendar Year (January 1 through December 31)

A 12-consecutive month period commencing on _____ and each anniversary thereafter.

(If no option is selected, Calendar Year shall be deemed to be selected)

Type of Plan:

The Employer is:

- A Governmental Plan within the meaning of section 414(d) of the Internal Revenue Code of a Public School.
- A Governmental Plan of an organization described in section 501(c)(3) of the Internal Revenue Code.
- A Plan (other than a plan described above) of an Employer that is an organization described in section 501(c)(3) of the Internal Revenue Code.

Plan Eligibility

Except as otherwise selected below:

- All employees are immediately eligible to make elective deferral contributions under the Plan.
- The Plan shall not include:
 - Employees eligible to participate under another section 403(b) Plan of the Employer.
 - Employees eligible to participate under a section 457(b) governmental Plan of the Employer.
 - Employees eligible to make a cash or deferral election under a section 401(k) Plan of the Employer.
 - Employees who are students performing services described in section 3121(b)(10) of the Internal Revenue Code.
 - Employees who normally work fewer than ____ hours per week (not to exceed 20). The equivalent of 20 hours per week is approximately 1,000 hours or less in 12-month period. *
 - Employees who are non-resident aliens described in section 410(b)(3)(C) of the Internal Revenue Code.

Our recommendation is that all employees except students performing services be allowed to participate in the Plan. The inclusion of all employees, including substitutes, will prevent an inadvertent violation of the eligibility requirements of Section 403(b) of the Internal Revenue Code (the “Code”) and its regulations.

*If the Employer opts to not allow employees working 20 hours or less per week to participate, the Employer must perform two eligibility tests. The first occurs at the time of employment. Does the Employer expect the employee to work less than 1,000 hours during the next 12-month period? If yes, the employee may be excluded from participation in the Plan. The second test occurs each year at the employment anniversary. Did the employee work 1,000 hours or more during the prior 12 months? If yes, they must be eligible for the Plan during the next year. If not, they are not eligible for participation.

Contributions

Limits on Elective Deferrals

The maximum amount of Elective Deferrals (per calendar year) shall not exceed the applicable dollar amount established under IRC Section 402(g)(1)(B), and adjusted for cost-of-living to the extent provided under Section 402(g)(4) for periods after the 2016 tax year.

The **minimum** annual deferral amount will be \$ _____ (the amount indicated can be no more than \$200).

Elective Deferrals Special Effective Date: _____ (may be left blank if effective date for Elective Deferrals is the same as the Plan or Restatement Effective Date; may not be earlier than the date on which the Employer first adopts the Elective Deferral component of the Plan, or January 1, 2009, whichever is later).

In addition to the annual 402(g) contribution limit and the 414(v) catch-up limit for those Participants age 50 or older, the Plan may include the following: (Check all that will be allowed)

- 402(g) Additional Catch-up for Participants with 15 or more years of service.

Choosing this option will require a worksheet and coordination of the two catch-up contribution limits. For accurate completion of the worksheet, the employer will need to provide the total of an employee's 403(b) salary reduction contributions for all years of employment with the employer.

****If this information cannot be provided, this option cannot be permitted under the Plan.***

Plan-to-Plan Transfers from another 403(b) Plan to this Plan

Roth 403(b) after-tax contributions

If Yes, effective date: _____

Rollovers into the Plan

If selected, the Plan will accept a direct rollover of an eligible rollover distribution from the following types of retirement plans. (Check each that applies or none.) Rollovers of after-tax contributions will not be accepted unless otherwise indicated.

An annuity contract described in section 403(b) of the Internal Revenue Code,

including after-tax contributions.

An eligible governmental plan under section 457(b) of the Code which is maintained by a State.

An individual retirement account or annuity (IRA) described in section 408(a) or 408(b) of the Internal Revenue Code that is eligible to be rolled over and would otherwise be includible in gross income.

Direct rollovers from other Roth 403(b) or Roth 401(k) plans are accepted into the Plan.

Not applicable if Roth Contributions are not permitted to the Plan.

A qualified plan described in section 401(a) or 403(a) of the Internal Revenue Code,

including after-tax contributions.

Employer Contributions (Currently make or intend to make Employer Contributions)

If selected, complete the 403(b) Employer Contribution Questionnaire on page 9 and 10

You made Employer contributions previously, but not currently

If selected, complete the 403(b) Employer Contribution Questionnaire on page 9 and 10

Distributions

Distributions from the Plan are allowed in the event of termination of employment, attaining age 59½, death of the Participant the Participant's total and permanent disability. The Plan may or may not allow distributions in the event of financial hardship.

Allow Financial Hardship Distributions from salary reduction contributions.

If a Plan allows financial hardship distributions, a Participant receiving such a distribution must cease all qualified retirement contributions for six months following the financial hardship distribution.

Allow Plan Loans

Availability of loans is subject to availability and additional conditions that may apply under a Participant's 403(b) investment option(s). AFPlanServ will prohibit any loans to a Participant with an outstanding defaulted loan under any retirement or deferred compensation Plan sponsored by the Employer.

Other Transactions

- The Plan will allow Exchanges to approved providers listed in the final written Plan.
- The Plan will allow Transfers Out of the Plan

Other Employer Plans:

- Do you currently sponsor a Plan under Section 457(b), 401(k), or 401(a)?
 - Other Plans? (If selected, please specify below)
-

Other Services:

Common Remittance:

As indicated below, the Plan hereby selects:

- Option A:** Administrative services *with* Common Remitter Services.
- Option B:** Administrative services *without* Common Remitter Services.

In the event the Plan selects administrative services *with* Common Remitter Services, Plan shall remit elective and non-elective 403(b) contributions directly to AFPlanServ® in an acceptable secure electronic format or by check on a timely basis. The Plan shall also provide complete payroll data and reconciliation files as needed to properly process the contributions. A file format document will be provided.

Other Provisions of the Plan

This section may be used to insert provisions for which there were no acceptable options/alternatives provided. **NOTE:** Any modifications should be carefully reviewed by Employer's legal counsel to ensure that changes do not adversely affect the Plan's qualification under Section 403(b) of the Code. An Employer that amends the Plan, other than to change the choice of options or procedures in the Adoption Agreement or to add certain sample or model amendments published by the Internal Revenue Service which specifically provide that their adoption will not cause the Plan to be treated as individually designed, will no longer participate in this section 403(b) prototype plan and will be considered to have an individually designed 403(b) plan.

Additional information needed:

In order to provide compliant administrative services for your 403(b) Plan, the following additional information and documentation are required as part of the setup process.

- Copies of all salary reduction agreements for employees contributing to the Plan.
- Participating employee list, containing the following information:
 - ✓ Name of employee
 - ✓ Amount of 403(b) salary reduction/deduction per pay period
 - ✓ Name of Investment Provider to whom deductions are remitted
 - ✓ Payroll frequency

403(b) Investment Provider Information

Investment Providers must sign the Investment Provider Agreement provided by AFPlanServ® in order to be approved under the Plan. (Please note that some Investment Providers may decline to become a Provider of the Plan)

Please use the following sections to provide the information below regarding your existing investment providers as well as any new providers you wish to add to your Plan. Please enter the name of the Provider, a contact name, a mailing address, a phone number and an e-mail address.

- ✓ Investment Providers to whom you have been sending contributions since 1/1/2009.
- ✓ Additional Investment Providers to whom you sent contributions to from 1/1/2005 to 12/31/2008, but not after 1/1/2009.
- ✓ New Investment Providers you wish to add to the Plan.
(Please note that some Investment Providers may decline to become a Provider of the Plan)

Providers to whom contributions have been sent since 1/1/2009.

(Use a separate sheet if needed)

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____ Include in Plan

Providers to whom contributions were sent from 1/1/2005 - 12/31/2008, but not after 1/1/2009

(Use a separate sheet if needed).

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Include in Plan

New Providers to be added to the Plan, if applicable.

(Use a separate sheet if needed)

Provider: American Fidelity Assurance Company

Mailing Address: P.O. Box 25520, Oklahoma City, OK 73125

Contact: Annuity Services Department

Email (if applicable): Annuity-Services@americanfidelity.com

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

Provider: _____

Mailing Address: _____

Phone Number: _____

Contact: _____

Email (if applicable): _____

403(b) Employer Non-Elective Contribution Questionnaire

Employer Name: _____ **State** _____

Employer hereby makes available to its employees a 403(b) Plan that provides for employer contributions in accordance with applicable employment agreements and/or collective bargaining agreements, and agrees that the following provisions shall govern all employer contributions and any earnings attributable to the employer contributions made to the Plan. The following Plan rules are applicable to Employer (Non-elective) contributions only.

A. Type and Allocation of Employer Contributions

Employer Non-Elective

Contribution Formula:

Discretionary Non-Elective Contributions

Fixed Non-Elective Contributions

Equal to _____ % of Compensation of each Participant eligible to share in allocations.

Other (describe):

Note: the formula described must satisfy the definitely determinable requirement under Reg. §1.401-1(b). If the formula is non-uniform, it will not satisfy this requirement.

Former Employees

If elected, Former Employees will share in the Non-Elective Contributions made by the Employer for a Plan Year. In any event, no contribution will be made after the end of the Participant's fifth taxable year after the year in which he terminated employment. See Plan Section 4.5. **If this option is not selected, Participants will not share in Employer Non-elective Contributions after the Plan Year in which their employment terminates, and Non-elective Contributions will be allocated based only on Compensation earned prior to the Severance from Employment.**

Disabled Employees

If elected, Employees who are permanently and totally disabled (as defined in Code §22(e)(3)) will continue to share in the Non-Elective Contributions made by the Employer for a Plan Year for:

A fixed period of _____ years, or

A period to be determined by the Employer, which shall be determined on a uniform and non-discriminatory basis for all Participants.

Matching Non-Elective

Contribution Formula: (select one)

Discretionary Matching

Fixed – uniform rate/amount

The employer will make matching contribution equal to _____ % of the Participant's Elective Deferral(s).

Matching Limit on Elective Deferrals:

In determining the Employer matching contribution above, only the following will be matched. (Leave blank if not applicable)

The percentage or dollar amount specified below (select one or both):

_____% of a Participant's Compensation.

\$_____.

A discretionary percentage of a Participant's Compensation or a discretionary dollar amount, the percentage or dollar amount to be determined by the Employer on a uniform basis for all Participants.

Maximum Matching Contribution

\$_____.

_____% of a Participant's Compensation.

EMPLOYER ACKNOWLEDGEMENTS AND SIGNATURES

By signing below, Employer acknowledges that it is an eligible educational organization as defined in Section 170(b)(1)(A)(ii) of the Code and the Plan is a governmental plan as defined in ERISA §3(32), 29. U.S.C.A. §1002(32).

I also certify that to the best of my knowledge and belief, the Plan will continue to qualify as one of the entities listed above and that the Employer will immediately notify (but in no event later than 30 days after the event causing the change in status) AFPlanServ® in writing if the Plan should lose its status as an eligible educational organization.

EMPLOYER:

Authorized Signature

Authorized Signer Name

Title

Date