

Mandatory Alternate Benefit Program (ABP) Salary Reduction Agreement and Carrier Allocation Form

Instructions

Section 1 – Agreement. Print your first and last name, today’s date and last four digits of your social security number.

Section 2 - Check one box. Please note that a suspension of contributions does not constitute a change.

Section 3 - Alternate Benefit Program (ABP) participants must complete this section.

1. An Alternate Benefit Program enrollee who does not designate an investment provider for their program contributions within 45 days of program participation, will be enrolled with the investment provider designated by the New Jersey Division of Pensions and Benefits as the default investment provider at the time of enrollment.
2. The default investment provider is authorized to accept employer and employee mandatory contributions and will invest the funds in a money market fund.
3. Contributions will continue to be sent to the default investment provider and invested in that money market fund until the ABP member designates an investment provider, completes an application with that investment provider, and notifies the employer of this action.
4. If the member is subject to delayed vesting, and is enrolled with the default investment provider, the member will be permitted to choose an alternate investment provider during the first year, and transfer the contributions deposited to that alternate investment provider.
5. There is no minimum retirement age under the ABP. A member may begin collecting an annuity, or may receive a cash distribution at any time after termination of employment; however, if you elect to receive an annuity or cash distribution after termination and return to public employment with the state of New Jersey, you may not participate in any State administered retirement system.

Additional Information: Please use the links to view and download a copy of the following:

- [Alternate Benefit Program](#)
- [Designated Service Providers Comparison Guide](#)
- [Designated Service Provider Campus Representatives](#)



**Mandatory Alternate Benefit Program (ABP)
Salary Reduction Agreement and Carrier Allocation Form**

Section 1:

It is hereby agreed by and between **(First and Last Name)** _____
(Employee) and The College of New Jersey (employer) that with respect to amounts earned on or after
(Date) _____, the employee’s bi-weekly basic salary will be reduced by the percentage indicated
below. At the same time, the employer agrees to remit periodically the sum of such deductions as a
premium on the annuity contracts which are purchased by the employer on behalf of the employee.

Last Four Digits of SSN _____

Section 2: **Initial Agreement** _____ **Change Contribution Percentage** _____
Change Designated Service Provider _____ **Suspend Contributions** _____

Section 3: Alternate Benefit Program (ABP) Investment Elections – Mandatory

The mandatory pension plan requires that each eligible employee participate with a 5% pre-tax contribution deduction from the employee’s base bi-weekly salary into the plan. The college also makes an 8% pre-tax contribution into the employee’s account.

Vesting: For most Alternate Benefit Program (ABP) members, vesting occurs in the beginning of the second year of ABP eligible employment.

A member is immediately vested if he/she satisfies the following conditions when the employee:

- a. Owns a retirement contract/plan that contains both employer and employee contributions from employment in the field of higher education **or**
- b. Has an active or vested account of a federal or state retirement system **or**
- c. The employee elects to transfer an active or vested New Jersey State-administered retirement system account to the ABP **and**
- d. The employee is entitled to receive benefits at a future date.

Based upon the requirements (above) are you vested in The College of New Jersey's contributions to your account? Y_____N ___

ABP members may change investment provider elections and/or allocations once per calendar quarter.

1. If you have **not** vested in your pension plan, you may select **one** investment provider.
2. If you **are** vested in the pension plan, you may select **any** number of investment providers.

Retirement Plan Investment Managers	Contribution to Equal 100
AXA Financial (Equitable)	
VOYA Financial Services	
MassMutual Retirement Services (formerly The Hartford)	
MetLife (formerly Travelers/Citistreet)	
VALIC	
TIAA-CREF	
Prudential	
Total:	100



PLEASE READ AND ACKNOWLEDGE IMPORTANT INFORMATION BELOW

This agreement shall be legally binding and irrevocable while employment continues unless the employer or the employee terminates the Agreement as of the end of any biweekly pay period, so that it will not apply to salary subsequently earned, by giving at least thirty days' written notice of the date of termination.

Contributions must be suspended and will resume the next tax year whenever the legal maximum deferral limits are met. I authorize the salary reduction set forth above and accept all tax consequences which may result.

This agreement supersedes all prior agreements and shall automatically terminate if employee's employment ends. Please consult with your individual legal or tax advisor with any specific tax questions.

The Salary Reduction Agreement establishes a contract between you and your employer. A Salary Reduction Agreement must be filed to establish participation and each time you change your percentage of reduction. Contact the designated service provider to set up an account and when deferral amounts change.

A new ABP participant must provide the Carrier Election and Allocation Form to enroll, and the form must be filed with the NJ Division of Pensions in order to indicate your investment carrier (s) choices.

To authorize participation in the plan, indicate the percentage (in whole numbers only) of your base salary contribution. The reduction amount shall not exceed your statutory exclusion allowance under the limitations of Section 415 and the regulations of the Internal Revenue Code.

I elect to allocate my total employee and employer tax sheltered contributions as indicated above.

Employee Signature _____ **Date** _____

HR Office Representative Complete Below – (Place a copy in the employee's file)

HR Signature/ Date Processed _____

EMPLID _____