

Salary Reduction/Deduction and Allocation Agreement

MassMutual Ascend Life Insurance Company • Annuity Investors® Life
Completed forms can be submitted to gdcfxdata@mmascend.com or
faxed to 513.357.3310



☐ New Participant ☐ Change to Existing Agreement

Effective Date: This Agreement shall take effect _____

****If requesting that salary reduction or deduction be discontinued, Agent Must notify employer directly and send copy to MassMutual Ascend.**

Plan Type

☐ 403(b) TSA ☐ Governmental 457(b) ☐ 401(k) or 401(a) ☐ SIMPLE IRA ☐ Traditional or Roth IRA ☐ Other _____

Employee Information

Name		Social Security Number
Date of Birth	Date of Hire	Employer Name

Salary Reduction or Salary Deduction

☐ \$ _____ per pay period (# of anticipated pay periods per year: _____)
☐ _____ % of compensation (Expected Annual Contribution \$ _____)

To the extent permitted by the Plan, my salary reduction election may include a catch-up contribution amount in excess of the normal contribution limits because by the end of the calendar year in which this election takes effect (check all that apply):

- ☐ I will be age 50 or older
- ☐ I will have completed 15 years of service with the Employer (TSA Programs only); and/or
- ☐ I will not yet be normal retirement age, but will reach it in one of the next three calendar years (457 Plans only).

ROTH ELECTION: To the extent permitted by the Plan, I elect that _____% (from 0% up to 100%) of my contributions be made as after-tax Roth 403(b)/401(k)/IRA/457(b) contributions. (If you don't complete this election, all of your contributions will be made on a pre-tax basis to the extent allowed by law.)

Allocation Instructions

Please indicate ALL of the annuity contracts with the Companies to which your contributions should be allocated. Allocations listed below will supersede all previous allocation instructions. Allocations may only be made to annuity contracts that are approved for use with the plan. Please note that if you provide amounts, they will be converted to percentages, when to the extent we determine practicable, and such percentages will apply to the contributions received, whether more or less than the total amount shown. If specific account information is provided by your employer or TPA, that information will supersede this form.

Re-direction of premium is subject to Home Office Approval

AILIC Fixed	AILIC Variable	GALIC	UTA	NHIC	Product Name	Policy #	Percentage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
(Percentages must add up to 100%) Total							

Acknowledgement

In accordance with the Plan identified above, I hereby elect to reduce my compensation, or to have a deduction from my compensation, in the amount or percentage elected above. I hereby authorize and direct the Companies to allocate contributions received under the Plan among the annuity contracts in the manner determined above. Any modifications I make may be subject to limitation by rules or regulations of the insurance, financial, and/or investment institutions. I request that this Agreement be put into effect as soon as practicable upon receipt by my employer and the Companies. I agree that no Company shall be responsible for any damages arising out of a delay in implementing these instructions so long as it has operated in a reasonable manner.

Employee Signature	Date	Financial Professional Signature	Date
Agent Number	Agent Name (Printed)		Financial Professional Phone Number