This Agreement is made between the University of North Texas Health Science Center (Employer) and the above named Participant. Effective with the salary check for the month of ______,____ that will be received on the first working day of_______,____. UNT Health Science Center agrees to reduce the Participant’s salary and contribute the amount indicated to the Participant’s 403(b) annuity contract(s) or custodial account(s) in accordance with applicable federal and state statutes and codes governing voluntary 403 (b) Tax Sheltered Annuities, the Optional Retirement Program, or the 457 Deferred Compensation Plan.

COMPLETE APPROPRIATE SELECTION:

___ A. Optional Retirement Program
    Reduce my gross compensation by the state mandated amount applicable each payday during the tax year which includes checks received January through December. Provide matching contributions from the state for retirement benefits. My selected carrier for the Optional Retirement Program is: ________________________________________________________________________ .

_________________________  __________________________  _________________________________
NAME OF ORP CARRIER

___ B. Tax Sheltered Annuity *
    Reduce my gross compensation by $______ per month thereafter. The tax year includes checks received January through December. My selected carrier is: ______________________________________________________________________________________ .

_________________________  __________________________  _________________________________
NAME OF TSA CARRIER

The Participant understands that (a) the purpose of the Employer in executing this Agreement is to provide the Participant with an opportunity to benefit from the provisions of Section 403(b) of the Internal Revenue Code of 1954 (as amended), (b), the Employer does not warrant any particular tax consequences to the Participant, (c) contributions to the 403(b) or 457 program will be made on a monthly basis.

This Agreement shall be legally binding and irrevocable with respect to all amounts earned, paid or otherwise made available while the Agreement is in effect. Either party may change or terminate this Agreement. UNT Health Science Center reserves the right to stop, reduce or suspend salary reductions on behalf of the Participant, at any time, when it has any reason to believe that any contribution level has been reached.

In witness thereof the parties below have affixed their signatures on the dates indicated.

_________________________  __________________________  _________________________________
EMPLOYEE'S SIGNATURE  HUMAN RESOURCE SERVICES REPRESENTATIVE

DATE______________________                       DATE__________________

* Must read and sign form on back

Distribution: Original - Human Resource Services
Copy - Employee
SALARY REDUCTION AGREEMENT

Your 403(b) Annual Limit is: $______________

Your 403(b) over age 50 catch up election: $______________

Your 15-years of service catch-up is $______________

I have been informed concerning the following conditions:

1. My election will be subject to retroactive options and rulings issued and to be issued by Internal Revenue Service affecting 403(b), 457, and Section 415 of the Internal Revenue Code.

2. Any change in interpretation of applicable sections of the Internal Revenue Code may require recalculation and a change in the amount and/or tax status of annuities purchased under provisions of that code.

3. In the event of any adverse ruling by the Internal Revenue Service regarding the calculation or my purchase of Tax Sheltered Annuities, I agree to be responsible to Internal Revenue Service and agree that the UNT Health Science Center at Fort Worth has my permission to make such adjustments in the amount of my Tax Sheltered Annuity as are deemed necessary by the University for compliance with such rulings.

4. The UNT Health Science Center at Fort Worth has my permission to change the amount of payments or to stop payments made toward purchase of my Tax Sheltered Annuities, at any time during the year, based on recalculation of my Tax Sheltered Annuity.

5. I am responsible for ensuring that the proper amounts are calculated based upon my own factual situation. I understand that the calculation is used only for guidance and does not cover all possible factual variations which may affect the calculation of my contribution limit formula.

6. I understand that a salary change or additional wage payment made during the year could alter my elective deferral amounts and may affect ORP contribution. I agree to notify the Human Resource Services Department when and if such changes occur.

I certify by signature that I have read the conditions stated above and agree to those conditions.

_________________________________  ________________________
EMPLOYEE SIGNATURE     DATE

HRM-55
Rev. 09-2005