

## TAX DEFERRED ANNUITY PLAN SALARY REDUCTION AGREEMENT FOR 2022

	HIS AGREEMENT, made between	(employee) and The
United	Hospital Fund of New York (the "Fund"), the parties hereto	agree as follows:
I.	Effective with respect to amounts earned on or after the first day ofimposed by Internal Revenue Code Sections 403(b), 415 and 402(g), \$20 reduced by \$ or% each pay period. The Fund will c annuity contract(s) purchased for the employee provided through Teache College Retirement Equities Fund (TIAA). The Fund reserves the right	9,500 for 2021, the employee's salary will be contribute the amount of such reduction to an ers' Insurance and Annuity Association /
II.	For employees age 50 or over, an additional catch-up contribution of \$\ each pay period shall be contributed. This amount under IRC Section 414(v), \$6,500 for 2022. This amount should be reviewee execution of this Agreement.	must not exceed the statutory limitation
III.	Subject to the limitations imposed by the Plan, the Employee directs <b>TIAA</b> to distribute to Employee any contributions determined to be in excess of any applicable contribution limits in accordance with governing legal requirements.	
IV.	It is understood that the amount(s) specified above will be paid to <b>TIAA</b> as premiums on Group Supplemental Retirement Annuity Contract(s) for the purchase of a non-transferable annuity contract to provide retirement benefits for employee.	
V.	This agreement shall be legally binding and irrevocable as to each of the parties hereto while employment continues through December 31, 2022; provided, however, that either party may terminate this Agreement as of the end of any month, so that it will not apply to salary subsequently earned, by giving at least fifteen days written notice of the date of termination.	
VI.		
VII.		
□IW	AIVE the opportunity to make elective salary deferral(s) to the	403b plan at this time. <b>NEW</b>
EMPL	OYEES: I affirm that I □ HAVE □ HAVE NOT made elective	salary deferral(s) earlier in
calenda	ar year 2022 through my previous employer.	
EMPL	OVEE:	
Divil D	Print your name	
EMPL	OYEE:	
	Signature	Date
Accept	ed by: Plan Administrator or Human Resources	Date
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