ORP Salary Reduction Acknowledgement and Change of Carrier

Instructions:

1. Complete appropriate items
2. Attach TRS-28 and TRS-29 forms for initial election
3. Return original to Employee Benefits
4. Employee retains copy

Name: _____ Social Security Number: _____

(Print or type)

Department: _____ Campus: _____

☐ Relative to my initial election to participate in the Optional Retirement Program, effective on or after the first of _____, I select _____ and certify:

(Name of carrier)

I. I understand that my decision not to become a member or not to continue membership in the Teacher Retirement System of Texas is **irrevocable** as required by law, unless I become an eligible employee in the Texas Public School System, other than in a Texas institution of higher education, or become employed in a position not eligible for continued participation in ORP.

II. I have been provided information regarding the benefits available through the Teacher Retirement System of Texas, including TRS's life and disability benefits, and it is my decision to select the ORP.

III. It is understood and hereby acknowledged that both my contribution and the State of Texas' contribution to the ORP will be treated as non-elective contributions under Selection 403(b) of the Internal Revenue Code of 1986. Additionally, my contribution to the ORP will be made by salary reduction as required by S.B. 1301 Acts of the 70th Texas Legislature. This agreement is irrevocable as long as I am a participant in the ORP or until it is determined by the appropriate authority that employee ORP contributions are elected within the meaning of Section 402 of the IRC of 1986.

IV. I understand that matching funds allocated by the State of Texas to my ORP are vested to me on the first day of the second year of participation.

☐ I hereby elect to change my Optional Retirement Program carrier effective on or after the first of _____, to _____.

(Name of New carrier)

Date of last carrier change _____.

This election supersedes all previous elections.

Date: _____ Employee Signature: _____

Carrier Representative – Provide the following:

Name: _____ Carrier: _____

Address: _____ Phone: _____

Accepted by:

Employee Benefits: _____ Date: _____