

STATE OF NEW JERSEY — DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 295
TRENTON, NJ 08625-0295

CHANGE OF
CONTRIBUTION
REQUEST

SUPPLEMENTAL ANNUITY COLLECTIVE TRUST

Please Print

1. Name _____ (_____)
LAST FIRST MIDDLE MAIDEN SURNAME

2. Address _____
STREET CITY STATE ZIP

3. Social Security Number _____

4. I am a member of:

- _____ Teachers' Pension and Annuity Fund
- _____ Public Employees' Retirement System
- _____ Police and Firemen's Retirement System
- _____ Judicial Retirement System
- _____ State Police Retirement System
- _____ Other

5. My Membership Number is: _____

Please change my rate of contribution to the SUPPLEMENTAL ANNUITY COLLECTIVE TRUST as follows:
(Rates may be only whole percentages, i.e., 1%, 2%, 3%, etc. up to 100% of available compensation up to the IRS annual limit in any combination of eligible programs.)

	100% of Deduction or Reduction	Discontinue Contributions
Regular — Deductions	_____ %	_____
*Tax Sheltered — Reductions	_____ %	_____

Changes are effective only at the beginning of a calendar quarter and on certification from the Division of Pensions and Benefits. This application should be filed at least 30 days in advance of the calendar quarter in which the change is requested.

List name of employer(s). (List all, if more than one.)

SIGNATURE OF PARTICIPANT

DATE

***Please be advised that a new salary reduction agreement has been entered into with this member and the salary reduction has been revised as indicated.**

LOCATION CODE NO. SIGNATURE OF CERTIFYING OFFICER

CHANGE OF CONTRIBUTION REQUEST CONFIRMATION

EFFECTIVE DATE ADMINISTRATOR'S SIGNATURE DATE