

HOUSING AGENCY RETIREMENT TRUST
NOTICE OF CHANGES FORM #160
(MARK APPLICABLE BLOCKS WITH X)

1. CORRECTION TO SOCIAL SECURITY NUMBER, DATE OF BIRTH, DATE OF HIRE, OR DATE OF PARTICIPATION

Correct Social Security No. _____ Correct Date of Birth _____
Correct Date of Hire _____ Correct Date of Participation _____

2. CHANGE OF VOLUNTARY AFTER-TAX CONTRIBUTION PERCENTAGE OR AMOUNT

- Discontinue Voluntary After-Tax Contributions effective _____, 20____
 Begin Voluntary After-Tax Contributions effective _____, 20____

Complete One: Start deducting _____ % of my basic compensation, or \$ _____ per month.

*I understand that I may change the percentage or dollar amount or stop voluntary contributions entirely as of the first day of any month. I also understand that if I desire to withdraw any amount from my voluntary contribution account, I may do so. The amount of this withdrawal cannot exceed the total value of my voluntary account balance. If I select a percentage above, my contribution will change whenever I have a salary change. If I select a dollar amount, it will remain the same unless I submit a change. I understand these additional contributions are subject to the following maximum IRS individual limit: **For calendar year 2023, the total of all contributions made to the Plan each year either by me or by my employer on my behalf cannot exceed whichever is smaller: \$66,000 or 100% of my annual salary. (The \$66,000 limit may be increased by the IRS each year after 2023.)***

3. DEFERRED RETIREMENT

My employer has requested that I continue my employment beyond my normal retirement date, and I consent to do so.

- I wish to continue my required contributions. I understand my employer will continue contributing to the Plan for me
 I wish to discontinue my required contributions to the Plan. I understand my employer will also discontinue contributions to the Plan for me.

4. CHANGE OR CORRECTION OF NAME (Review Your Beneficiary Designation. To Make A Change Use FORM #140)

It is hereby requested that the name of the Employee* Beneficiary Other
appearing in the Plan's file as _____
be changed to _____ because of _____

***Important - If your name is changing, please notify your payroll representative to ensure they change your name on the retirement billing spreadsheet, otherwise it will revert back to your previous name.**

5. LEAVE OF ABSENCE Effective Date of Leave _____, 20____

A temporary suspension of contributions to this Retirement Plan because of:

- Military Leave Pregnancy Illness or injury Other _____

During this leave of absence, the employee will not be receiving any compensation from this participating employer.

IMPORTANT: If my agency has Supplemental Death Benefit coverage, will it be kept in force? Yes No

6. RETURN FROM LEAVE OF ABSENCE Effective Date of Return _____, 20____

We hereby request reinstatement in this Plan as he/she has actively returned to work.

ALL INFORMATION LISTED BELOW MUST BE COMPLETED

Plan #: 598 _____ Employee's Social Security Number: _____
Employee's Name (Please Print): _____
Last First Middle

I certify that this information is correct.

Signed at (City, State) _____ this the _____ day of _____, _____
Month Year

Name of Employer

Signature of Agency Authorized Official Required

Signature of Employee
(Not Required for sections 5 & 6)

Agency keep **original**, employee keep a copy and **either fax form to: 1-973-712-7489 or email to: ADPRS.eforms@adp.com**
Housing Agency Retirement Trust, c/o ADP Retirement Services, PO Box 22669, Louisville, KY 40252-0669
PHONE: 1-888-801-3534