FX-0002-0215

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS

ADDITIONAL CONTRIBUTIONS TAX-SHELTERED (ACTS) PROGRAM
PROVIDER ELECTION AND ALLOCATION

Name _____ _____ _____
LAST FIRST MIDDLE INITIAL

Social Security No. _____ Membership No. (IF APPLICABLE) _____

Retirement System (IF APPLICABLE) ☐ PERS ☐ TPAF ☐ PFRS

Address _____
STREET OR RD# APARTMENT NO.

_____
CITY STATE ZIP

Daytime Telephone No. (_____) _____

AUTHORIZED INVESTMENT CARRIERS

Select any number of investment carriers and allocate the percentage of your contributions to each one, totaling 100%. Percentages must be whole numbers. *YOU MUST ESTABLISH A VALID ACCOUNT DIRECTLY WITH THE PROVIDER(S) YOU SELECT BEFORE COMPLETING THIS FORM.* Only two changes are allowed in any calendar year.

Check One: ☐ Initial Election ☐ Subsequent Election

	Carrier Account No.	Percentage
☐ AIG VALIC	_____	_____ %
☐ AXA Financial (Equitable)	_____	_____ %
☐ VOYA Financial Services	_____	_____ %
☐ MassMutual Retirement Services	_____	_____ %
☐ Met Life (formerly Travelers/CitiStreet)	_____	_____ %
☐ Prudential	_____	_____ %
☐ TIAA-CREF	_____	_____ %
		100%

I elect to allocate my total employee tax sheltered contributions as indicated above. This allocation becomes effective within 45 days of receipt of a properly completed form. I have read and understand the information on the back of this application.

Employee Signature _____ Date _____

EMPLOYER SECTION

Name of Employing Agency _____ Payroll No. _____

Address of Employing Agency _____

Certifying Officer Signature _____ Title _____

Telephone No. _____ Date _____

Mail completed form to: **Division of Pensions and Benefits, ACTS Program, PO Box 295, Trenton, NJ 08625-0295**

FOR DIVISION USE ONLY

SALARY REDUCTION AGREEMENT - CONFIRMATION OF RECEIPT BY DIVISION OF PENSIONS AND BENEFITS

Effective Date _____ Authorized Signature _____ Date _____

ADDITIONAL CONTRIBUTIONS TAX-SHELTERED (ACTS) PROGRAM

CARRIER ELECTION AND ALLOCATION

GENERAL INFORMATION

Employees of county colleges, state universities and colleges, the Commission on Higher Education, the Department of Education, and the Office of Student Assistance can participate in the Additional Contributions Tax-Sheltered (ACTS) Program. ABP members have the option to select the same individual providers through the regular Alternate Benefit Program.

A Provider Election and Allocation Form must be filed to identify the investment carrier(s) with which you want your contributions invested. If you are a new participant, this form must be accompanied by the Salary Reduction Agreement form.

INSTRUCTIONS FOR APPLICANTS:

Please read all information carefully when completing this form. Where applicable, indicate your name, mailing address, social security number, and telephone number where you may be reached during daytime working hours. If you are a member of a state-administered retirement system, check the name of the system and provide your membership number.

To authorize any investment provider(s), indicate in the relevant box if your request is an initial or a subsequent request. ***A SUBSEQUENT REQUEST WILL REPLACE ALL PREVIOUS SELECTIONS.*** Place a mark in the box to the left of the name of the provider(s) you have selected and provide your account number assigned with that provider. Enter the percent of the reduction that you want allocated to any provider(s). Percentages must be in whole numbers and totals must equal 100%.

Sign and date the form and have your certifying officer complete the employer information. A copy will be returned to you after confirmation of receipt indicating the date your reduction will take effect.

It is your responsibility to complete the necessary forms to establish a valid account with the carrier(s) you select for your investments. If you fail to establish an account with the provider(s), you may lose earnings from your contributions. Additionally, the provider(s) will return your contributions to the Division of Pensions and Benefits and your participation will be delayed.

INSTRUCTIONS FOR EMPLOYERS

Please enter the name, address and payroll number of your agency. The designated certifying officer must sign the form indicating his/her title, telephone number, and the date. Upon completion, return this form to:

Division of Pensions and Benefits
ACTS Program
PO BOX 295
Trenton, NJ 08625-0295