FX-0002-1122

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — DEFINED BENEFIT & DEFINED CONTRIBUTION BUREAU

P.O. Box 295, Trenton, NJ 08625-0295

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

PART 1 — MEMBER INFORMATION (To be completed by the member.)

ABP Membership Number (If applicable) _____

Retirement System (If applicable) ☐ PERS ☐ TPAF ☐ PFRS

Social Security Number _____ Date of Birth _____/_____/_____

Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *Zip*

Phone Number _____ Email _____

PART 2 — AUTHORIZED INVESTMENT CARRIERS (To be completed and signed by the member.)

Select any number of investment carriers and allocate the percentage of your contributions to each one, totaling 100 percent. 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.

Choose one: ☐ Initial Election ☐ Subsequent Election

	Carrier Account No.	**Percentage**
☐ Equitable (formerly AXA)	_____	_____ %
☐ Empower (formerly MassMutual)	_____	_____ %
☐ MetLife/Brighthouse (formerly Travelers/CitiStreet)	_____	_____ %
☐ TIAA	_____	_____ %
☐ Corebridge Financial (formerly AIG)	_____	_____ %
☐ VOYA Financial Services	_____	_____ %
		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.

_____ _____/_____/_____
Member's Signature *Date*

Sign this page and have your employer complete Part 3 on next page

PART 3 — EMPLOYER INFORMATION AND SIGNATURE
(Must be completed and signed by the employer's Certifying Officer.)

Name of Employing Agency _____ Payroll Number _____

Address of Employing Agency _____
Street *City* *State* *Zip Code*

_____ _____ _____/_____/_____
Print Certifying Officer Name *Signature* *Date*

_____ _____
Title *Phone Number*

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

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 if your request is an Initial Election or a Subsequent Election. **Note:** A subsequent election 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 the provider(s). Percentages must be in whole numbers and the total must equal 100 percent.

Sign and date the form and have your Certifying Officer complete the employer section. A copy will be returned to you as confirmation of receipt and indicate 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 NJDPB 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.

Return this completed form to:

New Jersey Division of Pensions & Benefits
ACTS Program
P.O. Box 295
Trenton, NJ 08625-0295

For NJDPB Use Only - Confirmation of Receipt

_____/_____/_____ _____ _____/_____/_____
Effective Authorized Date *Administrator's Signature* *Date*