DUKE UNIVERSITY 457(B) DEFERRED COMPENSATION PLAN
Salary Reduction Agreement

For Benefits Use Only

Pay Period Effective Date: ________________________  [☐ New  ☐ Change  ☐ Delimit]

SECTION 1: PARTICIPANT INFORMATION

Name: ________________________________  Duke ID: ______________________

Email: ________________________________
*If you have provided an email address, you will receive an email confirmation within 3 business days of receiving this form.

SECTION 2: EMPLOYEE CONTRIBUTION ELECTION

By this Agreement, made between Duke University and me, the parties hereto agree as follows:

Effective with respect to salary earned on or after ______________________ (which date is subsequent to the execution of this Agreement), the employee’s salary will be reduced by the amount indicated below.

The amount of salary reduction to be credited to my Section 457(b) account shall be:
(Please select one)

☐ A. Whole % of Salary  % (per pay period)
☐ B. Flat $ Amount $ (per pay period)
☐ C. Maximum Program Option $ (per pay period)
☐ D. Stop Contributions

The Agreement shall be legally binding and irrevocable as to each of the parties hereto while employment continues; provided, however, that either party may terminate or modify this Agreement as of the end of any month, so that it will not apply to salary subsequently earned, by giving at least thirty (30) day written notice of the date of termination.

SECTION 3: VENDOR ALLOCATION

I would like the following Investment Carrier Allocation:

<table>
<thead>
<tr>
<th>Investment Carrier</th>
<th>Contribution Allocation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelity</td>
<td></td>
</tr>
<tr>
<td>TIAA</td>
<td></td>
</tr>
<tr>
<td>VALIC</td>
<td></td>
</tr>
<tr>
<td><strong>Total must equal 100% →</strong> 100%</td>
<td></td>
</tr>
</tbody>
</table>

*Please note: If you are selecting a new investment carrier, please complete the investment carrier’s enrollment form to select your investment options.*

SECTION 4: ACKNOWLEDGEMENT AND AUTHORIZATION

This Agreement is hereby deemed to constitute my salary reduction agreement under the 457(b) Deferred Compensation Plan (“Plan”). I agree that salary deferrals under the Plan will not exceed the statutory applicable limit under Section 457(b) of the Internal Revenue Code. I also agree to all of the terms and conditions contained in the Plan, including the conditions that the Plan shall be unfunded and all amounts shall be paid from the general assets of Duke University.

________________________________________  ________________
Employee Signature  Date

________________________________________  ________________
Duke Benefits Signature  Date

*Please send this form to Benefits, Box 90502, 705 Broad Street, Durham, NC 27708 or fax to (919) 681-8774.*