ELECTIVE DEFERRAL AUTHORIZATION FORM
LOCAL UNION 124 IBEW – NECA 401(k) PLAN

Complete and Return to Employer

Participant Name_____ **SS#** _____

Employer Name_____ **Date of Hire**_____

☐**I am or** ☐ **I am Not related to employees of this Employer** ☐**Mark box if I am 50yrs or older**

ELECTIVE DEFERRAL ELECTION CHECK A BOX BELOW:

☐ **This is my initial Elective Deferral (effective immediately as a new hire & must begin with the 1st hr worked or may begin with the respect to paycheck that includes January 1 or July 1 in the pay period).**

☐ **This election is filed to change the amount of my current Elective Deferral Election (effective with respect to paycheck that include January 1 or July 1 in the pay period).**

☐ **This election is to stop my current Elective Deferral Election(effective the date signed by participant & employer).**

☐ **I do not currently wish to participate in the Elective Deferral(s).**

2026 401k Limits **$0.50¢ Increments Per Hour**

Age	Annual Max	Catch-Up	Max w/Catch Up	Max Per Hour Combined
Under 50	$24,500.00		$24,500.00	$0.50 to $12.00
50-59	$24,500.00	$ 8,000.00	$32,500.00	$0.50 to $15.50
60-63	$24,500.00	$11,250.00	$35,750.00	$0.50 to $17.00
64+	$24,500.00	$ 8,000.00	$32,500.00	$0.50 to $15.50

If a member's W-2 Wages Box 3 was at least $150,000.00 in 2025, & 50+ years old, then catch up contributions will need to be made as Roth contributions (for assistance please call the Benefit Office).

The Roth & Tax Deferred elections cannot be more than the above Max Per Hour Combined.

Tax Deferred Savings Contribution Effective on_____ **$**_____ **per hour**

Roth Contribution Effective _____**$**_____ **per hour**

I understand the Plan Administrator may amend or revoke this Election anytime, if the Plan Administrator determines necessary to ensure my elective deferrals do not exceed in a plan year the maximum amount permitted under sections 402(g) or 415(c) of the Internal Revenue Code, or necessary to ensure satisfaction of the nondiscrimination tests under section 401(k) of the Code for such plan year, or otherwise required by law. Also, this Election shall be revoked automatically upon the loss of eligibility to participate in the Plan, or my termination of employment with the Employer listed on this authorization form.

_____ _____

Date **Participant's Signature**

INSTRUCTIONS TO EMPLOYER

•Sign and Date Below •Email this Form to Fund Office to mrangel@ibew124benefits.org •Keep this Copy for your Files• Implement Payroll Deductions.

_____ _____

Date **Signature and Title of Employer Representative**

MLR/OPEIU#277