

# BIC U.S. 403(b)(9) Plan Enrollment Form



**A. Employee and Employer Information:**

Name of Employee: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Full time employee: Yes\_\_\_ No\_\_\_

Position/Title: \_\_\_\_\_

**B. Your Authorization:**

I understand the provisions of the Plan and elect to participate in the Plan through employee and/or employer contributions.

Effective date of payroll change: 01/01/2019

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Once this form is completed, signed, and dated, please retain a copy for your records, send the original copy to your employer.***