

**Salary Deferral Agreement
401(k) Plan**

Apollo Professional Solutions, Inc. 401(k) Plan

937620-01

Participant Information

Last Name			First Name			MI	Social Security Number							
Address - Number & Street									E-Mail Address					
City			State			Zip Code			Mo	Day	Year	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
()			()						Date of Birth			<input type="checkbox"/> Married	<input type="checkbox"/> Unmarried	
Home Phone			Work Phone			Do you have a retirement savings plan with a previous employer? <input type="checkbox"/> Yes or <input type="checkbox"/> No								

Salary Deferral Agreement

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superceded, or the employee ceases to be an eligible employee. This Agreement supercedes all previous agreements.

I understand that I may change the percentage of compensation or dollar amount contributed to the Plan only when and as allowed under the terms of the Plan. I also understand that it is my responsibility to comply with the Internal Revenue Code deferral limits; that any excess contributions will be distributed pursuant to Treasury regulation 1.402(g)-1, as amended; and that I may be responsible for any costs, including taxes and penalties, that I may incur as a result of such excess contributions.

Payroll Information

Specify one of the following:

- New Enrollment Restart Payroll Deductions Increase Payroll Deductions Decrease Payroll Deductions Stop Payroll Deductions

Specify the following:

- I elect to contribute _____% (per pay period) of my compensation as before-tax contributions to the 401(k) Plan until such time as I revoke or amend my election.

Note: The total of your before-tax deferrals cannot exceed 100% or \$16,500.00. If I am 50 years of age or older and I am eligible for a catch-up contribution, I understand I may exceed this total.

- I decline to make contributions to the Plan at this time.

Payroll Effective Date: _____
Mo Day Year

Date of Hire: _____
Mo Day Year

Required Signature(s) - I have completed, understand and agree to the terms of this Agreement and authorize the payroll deduction as indicated on this form.

Participant Signature

Date

Participant forward to Plan Administrator/Trustee

Authorized Plan Administrator/Trustee Signature

Date

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