



SALARY REDUCTION AGREEMENT

For GAFRI Company:

- Great American Life Insurance Company
Annuity Investors Life Insurance Company

1. EMPLOYER INFORMATION

Employer Name _____

- Plan: Section 403(b) Tax-Sheltered Annuity Program
Section 457 Deferred Compensation Plan
Section 401(k) Cash or Deferred Arrangement

2. SALARY REDUCTION INFORMATION

Subject to the annual contribution limits and other requirements of the Plan, I authorize the Employer to reduce my cash compensation in exchange for the prompt payment of equal amount to the Great American Financial Resources, Inc. company indicated above for deposit to a qualified annuity as a salary reduction contribution under the Plan. The amount of such reduction and payment shall be as follows:

% of my gross cash compensation
OR
\$ for number of pay periods
OR
\$ annual payment

To the extent permitted by the Plan, my salary reduction election may include a catch-up contribution amount in excess of the normal contribution limits because by the end of the calendar year in which this election takes effect:

- I will be age 50 or older;
I will have completed 15 years of service with the Employer (TSA Programs only); and/or
I will not yet be normal retirement age, but will reach it in one of the next three calendar years (457 Plans only).

To the extent permitted by the Plan, I elect that % (from 0% up to 100%) of my contributions be made as after-tax Roth 403(b)/401(k) contributions. (If you don't complete this option, all of your contributions will be made on a pre-tax basis.)

3. EFFECTIVE DATE

This Salary Reduction Agreement shall take effect as soon as permitted under the Plan and as soon as administratively feasible or, if later, _____, 20_____.

Please discontinue remittance to _____ as of this effective date.
(company name)

4. DURATION

This Salary Reduction Agreement replaces any earlier Salary Reduction Agreement I have made under the Plan and shall be legally binding and irrevocable with respect to amounts earned while it is in effect. This Salary Reduction Agreement will remain in effect as long as I remain an eligible employee under the Plan or until I provide the Employer with a written request to end my salary reduction contributions or submit a new Salary Reduction Agreement, as permitted under the Plan.

Employee Signature Employee Name (Printed) Social Security Number

Ben Sarsozo
Agent/Representative Name (printed) Date

For Employer Use Only

Date Received By
Date Effective