



**403(b) Retirement Savings  
Plan Verification/Waiver Form**

To determine whether you may already satisfy all or part of the one-year of service eligibility requirement to receive contributions from the College under the College of the Holy Cross 403(b) Defined Contribution and Group Supplemental Retirement Plan, please complete Section 1 and forward the form to your former employer to complete Section 2. This form will be processed as soon as administratively feasible upon receipt in Human Resources and in coordination with payroll processing (within 1-2 payroll periods).

**Section 1: Completed by Holy**

**Cross Employee**

Please complete and forward the form to your former employer.

Name and Address of Your Former Employer: \_\_\_\_\_ Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Last 4 digits of your Social Security #: \_\_\_\_\_

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

Date of Hire at Holy Cross: \_\_\_\_\_ Position/Title: \_\_\_\_\_ If  
previously employed at Holy Cross, please provide your employment dates: \_\_\_\_\_

**Section 2: Completed by Former Employer**

Your former employee, named above, has recently become an employee at College of the Holy Cross. To determine their eligibility for the Holy Cross 403(b) plan, please provide the following information and return this form to College of the Holy Cross. If you have questions please call 508-793-3568.

**Name of prior employer:**

\_\_\_\_\_ Please spell out with no  
abbreviations

Is this an educational organization, teaching institution, institution of higher education or non-profit  
educational institution or organization eligible to sponsor a retirement plan under Section 403(b) of the  
Internal Revenue Code: ☐ Yes ☐ No

Former employee's Date of Hire in a Benefits Eligible Position: \_\_\_\_\_

Date of Termination from Benefits Eligible Position: \_\_\_\_\_

**Retirement Savings Plan**

Date Participation Began: \_\_\_\_\_ Date Participation Ended: \_\_\_\_\_

Type of plan: ☐ 403(b) ☐ 401(a) ☐ 401(k) ☐ Defined Benefit

Amount of former employee's contributions to Retirement Savings Plan since January 1 of current calendar  
year: \$ \_\_\_\_\_

Signature of Representative of Prior Employer: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

**Return this form to:**

**Preferred: Requesting**

**Former Employee or:**

College of the Holy Cross

Attn: HR/Benefits

One College Street

Worcester, MA 01601

**Email** to both:

**[dkenneal@holycross.edu](mailto:dkenneal@holycross.edu)**

**[arochoa@holycross.edu](mailto:arochoa@holycross.edu)**