# 457 DEFERRED COMPENSATION PLAN EMPLOYEE ENROLLMENT/CHANGE FORM

ICMA Retirement Corporation
Attn.: Records Management Unit
P.O. Box 98150
Washington, DC 20090-8150

- Use this form to Enroll or make Changes to your 457 Plan.
- Read instructions on the back carefully before completing this form. Please print legibly in blue or black ink.
- **Return this form to your employer promptly. Your employer must provide the form to ICMA Retirement Corporation before the payroll date of your first deferral.**
- Note: It is important to review your next paystub to confirm your enrollment/change has been processed correctly.
- If making changes, complete Section 1 and then proceed to the appropriate section to make your changes. If new enrollment, all sections must be completed.

## 1 Required Participant Information

*Information in this box must be completed to avoid processing and investment delays*

☐ Check if new address

(check one) ☐ NEW ENROLLMENT ☐ CHANGE

Employer Plan Number | Employer Plan Name | State | Social Security Number

Full Name of Participant: Last | First | MI.

Sex: ☐ M ☐ F

Mailing Address/Street:

City: | State: | Zip Code:

Date of Birth: Month / Day / Year

## Personal Information

☐ Check if change in this section

Job Title:

Daytime Phone Number: Area Code

Home Phone Number: Area Code

Date Employed/Retired: Month / Day / Year

Marital Status: ☐ Married ☐ Single

Retired? ☐ Check if yes

## 2 Beneficiary Designation

☐ Check if change in this section

| Name | Relationship to you | Address | Social Security Number (if certain) | % of benefit |
|---|---|---|---|---|
| Primary Beneficiaries: | | | | |
| | | | | |
| Contingent Beneficiaries, if any: | | | | |
| | | | | |

## 3 Amount of Deferral

*(My instructions for my employer)*

☐ Check if change in this section

I authorize my employer to defer _____ % or $ _____ from my pay each pay period.

As an individual who has reached or will reach age 50 by December 31 of this year, I also authorize my employer to defer an additional $ _____ from my pay each pay period. (For more details see instructions on back of form.)

Note to Employers: This separate item is provided to allow you to separately track these "age 50 catch-up contributions" for purposes of limit testing.

Deferrals will begin on ____ Month ____ Day ____ Year. My current annual salary is $ _____.

***For employer use, if applicable:*** ***The employer will contribute _____ % or $ _____. The total deferral will be _____ % or $ _____.***

## 4 Allocation of Future Contributions

☐ Check if change in this section

Allocate your future contributions in percentages among the available fund choices. Allocation percentages must total 100 percent. If the allocation total does not add up to 100 percent then the remainder will be allocated to the PLUS Fund. **If no selection is given, your contribution will be allocated to the default fund selected by your employer.** Use whole percentages (e.g., 50 percent, not 33 1/3 percent). Do not use fixed dollar amounts.

Fill in the boxes at right with codes of the fund(s) you want to invest in. A list of funds and codes can be found on the *Investment Options* sheet.

State law, local law, or your employer may place restrictions on investment in these funds.

**SEE THE *INVESTMENT OPTIONS* SHEET FOR FUND CODES**

| ALLOCATION | | | |
|---|---|---|---|
| Code | Percent | Code | Percent |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | TOTAL = 100% |

## 5 Employee Signature

**I acknowledge that I have read and agreed to the disclosure (see 5 & 6) on the back of this form.**

Participant Signature | Date

## 6 Employer's Authorization

Authorized Employer Official's Signature | Date | Employer Plan Number