PAYCHECK CONTRIBUTION ELECTION
GOVERNMENTAL 457(b) PLAN

RW19

Wyoming Retirement System 457 Deferred Compensation Plan

State Government Employee **93001-01** ❑
Other Government Employee **93001-02** ❑

Participant Information

Last Name | First Name | MI

Social Security Number

Address – Number & Street

E – Mail Address

City | State | Zip Code

Mo Day Year ❑ Female ❑ Male ❑ Married ❑ Unmarried

( ) Home Phone

( ) Work Phone

Date of Birth

Contribution Election

Agency Name _____ Agency Number _____

Specify one of the following:

❑ Increase Payroll Deduction ❑ Restart Payroll Deduction ❑ Military Make-up for Year _____
❑ Decrease Payroll Deduction ❑ Contribution Type

Specify the following:

❑ I elect to contribute $ _____ (per pay period) of my compensation as **pre-tax** contributions to the Governmental 457 Deferred Compensation Plan until such time as I revoke or amend my election. **If this is left blank, any prior election will remain in effect.**

❑ I elect to contribute $ _____ (per pay period) of my compensation **after-tax** as a designated Roth contribution to the Governmental 457 Deferred Compensation Plan until such time as I revoke or amend my election. **If this is left blank, any prior election will remain in effect.**

I understand that I may contribute a minimum of $20 per month and the total of my pre-tax and after-tax contributions cannot exceed the standard maximum of $19,000 in 2019. If I am 50 years of age or older during the calendar year, I may choose to contribute an additional Age 50+ Catch-up Contribution of up to $6,000 in 2019. (Please note: You must indicate your date of birth in the indicated section above to be eligible to contribute above the standard maximum.)

I understand that I may change the dollar amount contributed to the Plan by electing a change in the **month prior to** when it will take effect.

Payroll Effective Date:

Mo Day Year

Paycheck Contribution Election

This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superseded, or the employee ceases to be an eligible employee.

Required Signatures

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**

Authorized Plan Administrator/Trustee Signature **Date**

Participant fax or mail to Deferred Compensation **Plan Administrator** at:
Wyoming Retirement System
6101 Yellowstone Road, Suite 500
Cheyenne, WY 82002
Phone#: 1-800-989-9324
Fax#: 1-307-777-3621
Web site: www.wrsdcp.com