

**PAYCHECK CONTRIBUTION ELECTION  
GOVERNMENTAL 457(b) PLAN**



WRS

**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
( )	( )	( )	( )			
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     Final Deferral of Accrued Leave     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 \$18,000 in 2017. 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 2017. (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This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superseded, or the employee ceases to be an eligible employee.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.

_____ <b>Participant Signature</b>	_____ <b>Date</b>
_____ <b>Authorized Plan Administrator/Trustee Signature</b>	_____ <b>Date</b>

**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