PAYCHECK CONTRIBUTION ELECTION
GOVERNMENTAL 457(b) PLAN

WRS Wyoming RETIREMENT SYSTEM

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 ❑ 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 $22,500 in 2023. 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 $7,500 in 2023. (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This Agreement shall apply to all compensation paid from the effective date specified, until cancelled, superseded, or the employee ceases to be an eligible employee.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 Signature

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**

Employees: Please return to your HR or Payroll office for processing.
Phone #: 1-800-701-8255
Website: www.wrsdcp.com