FAIRFAX COUNTY GOVERNMENT
457 EMPLOYEE CHANGE FORM

PLEASE CHECK ALL WHICH APPLY:

Change for: □ **VALIC** Plan #59356001 □ **ICMA-RC** Plan #301887 □ **NATIONWIDE** Plan # 000816 □ **T. ROWE PRICE** Plan #7-58001

□ **Address Change – Part A** □ **Change Biweekly Amount – Part B** □ **Beneficiary Change – Part D**

(See Part C for information on investment allocation changes, fund transfers, and provider to provider asset transfers).

PART A: EMPLOYEE INFORMATION (Must be completed)

Social Security Number: _____ -_____- _____ Date of Birth: _____ Phone: H _____ W_____

Name: _____
Last First Middle Initial

New address: _____
No. Street

_____
City State Zip Code

PART B: CHANGE BIWEEKLY DEFERRED COMPENSATION AMOUNT - Your minimum deferral must be $10 per vendor.

Check here if you are deferring to more than one vendor □ yes □ no

To increase or decrease your amount, enter the total dollar amount or percentage of your compensation you want to defer biweekly. To stop your amount, enter $0.00 in the dollar amount field.

□ **AIG VALIC** $_____ or _____% □ **ICMA-RC** $_____ or _____%

□ **NATIONWIDE** $_____ or _____% □ **T. ROWE PRICE** $_____ or _____%

Are you participating in the catch up provision: □ yes □ no
Note: Declaration of Normal Retirement Age form required to defer up to 2x normal limit - not required for over age 50 limit

Are you terminating employment and electing the amount you want to defer from your annual leave and compensatory time payoff? □ yes □ no
Last day worked: _____

Payroll deferral changes are processed in the first available pay date in the month following receipt of the form.

PART C: INVESTMENT ALLOCATIONS - To change your investment allocations or to transfer assets from one fund to another fund within a provider, call the numbers listed below. To move assets from one provider to another provider, contact the Department of Human Resources at 324-4995.

VALIC 1-888-568-2542 ICMA-RC 1-800-669-7400 NATIONWIDE 1-800-769-4457 T. ROWE PRICE 1-888-457-5770

PART D: BENEFICIARY INFORMATION - Designated beneficiaries will be on record for all plan providers.

Primary Beneficiary:

Name: _____ **Social Security Number:** _____ **Date of Birth:** _____

Relationship: _____ **% of Benefits** _____

Name: _____ **Social Security Number:** _____ **Date of Birth:** _____

Relationship: _____ **% of Benefits** _____

Contingent Beneficiary:

Name: _____ **Social Security Number:** _____ **Date of Birth:** _____

Relationship: _____ **% of Benefits** _____

Name: _____ **Social Security Number:** _____ **Date of Birth:** _____

Relationship: _____ **% of Benefits** _____

PART E: SIGNATURE – (Must be completed): As a Participant, I agree on behalf of myself and my heirs, successors and assigns, to hold harmless Fairfax County, Participating Employers, the Administrators and Trustee, from any liability for acts performed in good faith relating to the Deferred Compensation Plan, including, but not limited to acts relating to the investment of my Participation Account.

_____ _____ _____ _____
Participant **Date** **Plan Administrator** **Date**

Submit completed form to Employee Benefits, DHR or fax to 703-802-8795.