



Town of Cary
457 Deferred Compensation Plan
Salary Reduction Authorization Form

Employee's Name _____

Employee's Social Security Number _____

Date of First Effective Salary Deferral _____

Deferral Amount (\$) per Pay Period (26 Pay Periods Per Year) _____

I wish to designate the following Beneficiary (or Beneficiaries). Please indicate Name, Relationship and SSN if available.

Primary

Contingent

I understand that I may change the amount deferred from my paycheck by submitting a new Salary Reduction Authorization to the Town of Cary Human Resources Department.

Employee's Signature _____

Date Signed _____