



457 Deferred Compensation Plan  
Simplified Employee Change Form

**For Change in Amount of Deferral Only**

Employer Plan Number: **302174**

Employer: **CITY OF LYNCHBURG**

Employee # or SSN: \_\_\_\_\_

Full Name of Participant: \_\_\_\_\_

I authorize the City of Lynchburg to defer \$ \_\_\_\_\_ from my paycheck each pay period beginning with the paycheck I receive on \_\_\_\_\_.

This change will be effective beginning with the next pay period if no paycheck date is indicated.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

**PLEASE SEND COMPLETED FORM TO:**

HUMAN RESOURCES DEPARTMENT  
900 CHURCH STREET  
3<sup>RD</sup> FLOOR  
LYNCHBURG, VA 24504  
FAX: (434) 845-4304 PH: (434) 455-4200

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**PAYROLL USE ONLY:**

Deferral Amount \$ \_\_\_\_\_

Date Processed: \_\_\_\_\_ By: \_\_\_\_\_