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
3RD FLOOR
LYNCHBURG, VA 24504
FAX: (434) 845-4304 PH: (434) 455-4200

PAYROLL USE ONLY:

Deferral Amount $_____

Date Processed: _____ By: _____

Updated 5/21/2010