

FAIRFAX COUNTY GOVERNMENT – 457 PLAN NEW ENROLLMENT FORM

PART A: EMPLOYEE INFORMATION

Social Security Number: _____ Date of Birth: _____ Phone: H: _____ W: _____
 Name (Last / First / MI): _____
 Address: _____
 City: _____ State: _____ Zip: _____

PART B AMOUNT OF DEFERRAL AND INVESTMENT ALLOCATION

Indicate the TOTAL dollar amount or percentage of your pay you wish to have deferred from **each** paycheck. The minimum deferral is \$10 **Deferrals begin on the first available pay date in the month following receipt of the completed form.**

Are you participating in "catch up"? yes no Catch-up participants must have a Declaration of Normal Retirement Age Form on file

Are you terminating employment and electing the amount you want to defer from your annual leave and compensatory time payoff? yes no

Using whole percentages (e.g. 25%), select your investment allocation. The total must equal 100%.

T. ROWE PRICE \$ _____ OR _____ % 7-58001

TRP Retirement 2040	TRRD	PD	_____ %	TRP International Stock	PRITX	37	_____ %
TRP Retirement 2035	TRRJ	H4	_____ %	TRP Small-Cap Stock	OTCFX	65	_____ %
TRP Retirement 2030	TRRC	MZ	_____ %	TRP Mid-Cap Growth	RPMGX	64	_____ %
TRP Retirement 2025	TRRH	H3	_____ %	TRP Blue Chip Growth	TRBCX	93	_____ %
TRP Retirement 2020	TRRB	GH	_____ %	TRP Equity Index 500	PREIX	50	_____ %
TRP Retirement 2015	TRRG	H2	_____ %	TRP Capital Appreciation	PRWCX	72	_____ %
TRP Retirement 2010	TRRA	AU	_____ %	TRP Equity Income	PRFDX	71	_____ %
TRP Retirement 2005	TRRF	H1	_____ %	TRP New Income Fund	PRCIX	43	_____ %
TRP Retirement Income	TRRI	SE	_____ %	TRP U.S. Treasury Intermediate	PRTIX	66	_____ %
				TRP Stable Value	N/A	R9	_____ %
TRP Personal Strategy Growth	TRSG	13	_____ %	TOTAL MUST EQUAL 100 %			
TRP Personal Strategy Balanced	TRPB	12	_____ %				
TRP Personal Strategy Income	PRSI	11	_____ %				

PART C: BENEFICIARY INFORMATION (required). Percentages must equal 100%. You must use whole percentages, (e.g. 25%).

Primary Beneficiary:

Name: _____	Relationship: _____	Name: _____	Relationship: _____
Social Security Number* _____	Birthdate* _____	Social Security Number* _____	Birthdate* _____
Percent: _____ %		Percent: _____ %	

Contingent Beneficiary (if no primary beneficiary can be paid):

Name: _____	Relationship: _____	Name: _____	Relationship: _____
Social Security Number* _____	Birthdate* _____	Social Security Number* _____	Birthdate* _____
Percent: _____ %		Percent: _____ %	

* Please provide requested information if it is available.

PART D: SIGNATURE (required)

As a participant, I agree on behalf of myself and my heirs, successors and assigns, to hold harmless Fairfax County, the Administrator and the 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. I understand that the 457 plan has a single aggregate limit that includes contributions under every 457 plan. Therefore, if I had or will have 457 plan contributions through another employer, I understand I need to ensure that the combined 457 plan contributions do not exceed the limits for the plan year.

_____ Signature of Participant	_____ Date	_____ Plan Administrator	_____ Date
-----------------------------------	---------------	-----------------------------	---------------

Print Name (Last, First, Middle Initial)

PP _____

Submit completed form to the Dept. of Human Resources, Employee Benefits or fax it to 703-802-8795

Rev.02/24/2011