DCP DEFERRED COMPENSATION PROGRAM

PARTICIPATION AGREEMENT

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

Mail To:
PO Box 40931
Olympia, Washington 98504-0931
Toll Free: 1-888-327-5596
TDD: 1-877-847-6041

Sample

Social Security Number	Employer Name		
Employee Name Last First Middle Initial		Day Phone ( )	
Street Address		Evening Phone ( )	
City	State	Birthdate MM DD YYYY	Gender ☐ M ☐ F

Deferral Information

I authorize my employer to defer $ _____ OR _____% from my pay monthly (see instructions).

Investment Allocations (Use whole percentages only)

(Fund ID)	Fund Name		(Fund ID)	Fund Name	
(10)	Savings Pool	_____%	(40)	Fidelity Equity Income	_____%
(25)	WA State Bond Fund	_____%	(50)	US Stock Market Index	_____%
(70)	WA State Short-Horizon	_____%	(20)	US Small Stock Index	_____%
(71)	WA State Mid-Horizon	_____%	(60)	Fidelity Independence	_____%
(30)	WA State Social Balanced	_____%	(75)	Fidelity Growth Company	_____%
(72)	WA State Long Horizon	_____%	(77)	Fidelity Overseas	_____%

TOTAL must equal **100%**

Beneficiary Designation

I understand if I select more than one Primary Beneficiary or more than one Contingent Beneficiary, the total percentage(s) (whole numbers only) for each category must add up to 100%. I wish to designate the following beneficiary(ies) in accordance with the provisions of the Plan:

Primary ☒	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip
Check One: ☐ Primary ☐ Contingent	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage %
	Address: Number	Street	City	State	Zip

Important: Read before signing. I authorize my employer to deduct the amount or percentage set forth above each month and transmit to the Deferred Compensation Program. I further authorize my employer to deduct any deferral changes I request through the Deferred Compensation Program in the future. This agreement will continue until further notification by me, as set forth in the plan. I understand a plan expense will be applied to my account value. I acknowledge I have read and understand all sections of the "Memo of Understanding" on the reverse side of this agreement.

X_____ Employee Signature Date

DRS D 112 (06/03) White Copy - DRS Pink Copy - Employer Yellow Copy - Participant