



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

Social Security Number		Employer Name			
Employee Name Last		First		Middle Initial	
Street Address		Day Phone ( )			
City		State		Evening Phone ( )	
Birthdate MM DD YYYY		Gender <input type="checkbox"/> M <input type="checkbox"/> 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					<b>100%</b>

**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:

<input checked="" type="checkbox"/>	Primary	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage
Address: Number Street City State Zip						
<input type="checkbox"/>	Check One:	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage
<input type="checkbox"/>	Primary Contingent	Address: Number Street City State Zip				
<input type="checkbox"/>	Check One:	Social Security Number	Name: Last, First, MI	Relationship	Date of Birth	Percentage
<input type="checkbox"/>	Primary Contingent	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.

\_\_\_\_\_  
Employee Signature Date

DRSD112(06/03) White Copy - DRS Pink Copy - Employer Yellow Copy - Participant