



ALAMEDA COUNTY DEFERRED COMPENSATION PLAN

Plan No: 0 0 6 8 0 9

Sub Plan No: 0 0 1 8 8 1

1 PARTICIPANT DATA
Employee ID No:
First Name: MI Last
Address:
City: State:
Zip Code: Department: QIC:
Home Telephone: Work Telephone:
Date of Birth: Date Employed: Sex: Male Female

2 TYPE OF PAYROLL MODIFICATION REQUEST
A. PAYROLL MODIFICATION
B. DISCONTINUANCE
C. RESTART
D. CATCH-UP

3 PARTICIPANT AUTHORIZATION
THIS FORM MUST BE ACCOMPANIED BY A COPY OF YOUR LATEST PAYCHECK STUB.
Payroll changes are effective the month following receipt of this form by the Plan Administrator at Alameda County Treasurer's Office, and not less than two (2) pay periods.
Participant Signature: X Date:

Please return this form to: Alameda County Treasurer's Office, Attn: DC Admin, 1221 Oak Street, 1st Floor, Room 131 Oakland, 94612 or interoffice mail QIC 20114 or fax 510- 272-3856

4 EMPLOYER'S AUTHORIZATION - Treasurer's Office Use Only
Employer Signature: X Date: