DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF TREASURY – BUREAU OF DEFERRED COMPENSATION

STATE OF FLORIDA DEFERRED COMPENSATION PLAN

DEFERRALS FROM SPECIAL SUPPLEMENTAL PAY

Please print clearly in ball-point pen, and press firmly to ensure that all copies are legible. Initial any corrections or changes.

Investment Provider: ☐☐☐

Section 1 - PARTICIPANT INFORMATION (Please PRINT NAME EXACTLY as reported to your payroll office)

Name (First, MI, Last) _____ SSN* _____

Street Address: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip: _____ Date of Birth: /☐☐/☐☐/☐☐

Phone Numbers: Home (_____)_____ Work (_____)_____Email Address: _____

Agency Name: _____

***Your disclosure of your social security number or taxpayer identification number is required. Section 112.215 F.S. authorizes the creation of the State of Florida Deferred Compensation Plan, which is intended to qualify for tax deferral pursuant to 26 USC 457. Use of the identifying numbers is mandated by 26 USC 6109. Your social security number or taxpayer identification number will be used as an identifying number for purposes of federal tax law.**

PARTICIPANT (EMPLOYEE) READ CAREFULLY

- **You will not be able to defer all of your special supplemental payment.** Your entire supplemental payment will be taxed for Social Security and Medicare. Social Security and Medicare amounts are subject to Federal Income (withholding) tax. The State Payroll System uses a formula that calculates the maximum possible deferral. The amount deferred will not be subject to Federal Income Tax. **Due to manual calculations and processing, a small amount may be made payable to you after the deferred compensation deferral is sent to your investment provider company.**
- **Your deferral will not be invested at the time of payment,** as are deferrals from a regular payroll. This is a manual process that requires several business days from the date of your net payment.

NOTICE

- **YOU ARE RESPONSIBLE FOR GIVING A COPY OF THIS FORM TO YOUR PERSONNEL/PAYROLL OFFICE.**
- **DO NOT GIVE PARTICIPANT ACTION FORMS TO YOUR PERSONNEL/PAYROLL OFFICE.**
- **RETURN THE STATE AND INVESTMENT PROVIDER FORM COPIES TO THE INVESTMENT PROVIDER COMPANY FOR PROCESSING.**

I understand that it is my responsibility to coordinate this request with my Personnel/Payroll Office and give them a copy of this form as noted above. I further understand that MY DEFERRAL WILL NOT BE MADE UNLESS MY PERSONNEL/PAYROLL OFFICE RECEIVES THIS FORM. I WILL CONTACT MY INVESTMENT PROVIDER COMPANY IMMEDIATELY IF I SHOULD RECEIVE MY SUPPLEMENTAL PAYMENT WITH NO DEFERRED COMPENSATION CONTRIBUTION WITHDRAWN.

I understand that my failure to do so could delay my benefit payments.

_____ _____

Participant Signature Date | State Office or other Authorized Signature Date

_____ _____

Deferred Compensation Specialist Signature Date | Deferred Compensation Specialist (Print Name)

Original-State; Copies-Participant, Investment Provider, Personnel/Payroll Office

DEPARTMENT OF FINANCIAL SERVICES

Division of Treasury – Bureau of Deferred Compensation

STATE OF FLORIDA DEFERRED COMPENSATION PLAN

PARTICIPANT ACTION FORM

Investment Provider __________

Requested Action
- ☐ Enrollment
- ☐ Increase Deferral
- ☐ Decrease Deferral
- ☐ Stop Deferral
- ☐ Address/Email/Phone Number Change
- ☐ Beneficiary Change
- ☐ Pay Cycle/Center Change
  - ☐ From Biweekly to Monthly
  - ☐ From Monthly to Biweekly
- ☐ Name Change From: __________________
- ☐ Special Instructions: _____________________

Replacement Information for Company to Company Transfers (attach form)
- ☐ Stop Deferral with: _________
- ☐ Decrease Deferral with: _______to $_______ **OR** __ __ . __ __% per pay period

Deferral From Special Supplemental Payroll (attach form) (leave Section 2 blank)
- ☐ Accrued Leave **OR** ☐ Other (ie: Merit or Retroactive)
- ☐ Defer Maximum **OR** ☐ Defer Up To $ ______________
- ☐ Entering DROP

"Catch-Up" Provision (Cannot do Standard and 50 + in the same calendar year)
- ☐ 50 + Catch- Up **OR** ☐ Standard Catch Up
  - ☐ Indicator already set
  - ☐ Apply (Attach application)/Begin date:____/____/_____

Section 1-PARTICIPANT INFORMATION (Please CLEARLY PRINT NAME exactly as reported to your payroll office)

Name (First, MI, Last) ____ SSN* ____________________________

Street Address: ____ Email Address: ____________________________________

City: _________________________________ State: _____ Zip: _______________ Date of Birth: _____ / _____ / _____

Phone Numbers: Home (______)_____________ Work (______)_________________ ☐ Male ☐ Female

***Your disclosure of your social security number or taxpayer identification number is required. Section 112.215 F.S. authorizes the creation of the State of Florida Deferred Compensation Plan, which is intended to qualify for tax deferral pursuant to 26 USC 457. Use of the identifying numbers is mandated by 26 USC 6109. Your social security number or taxpayer identification number will be used as an identifying number for purposes of federal tax law.**

Section 2-PAYCYCLE/DEFERRAL INFORMATION

Pay-Cycle: ☐ Monthly ☐ Bi-Weekly Annual Salary: _____________

- Are you paid on a Seasonal Pay schedule?: ☐ No ☐ Yes – Indicate valid pay months: From ___________ to __________
- Are you paid by a Non-Centralized Payroll Employer/University? ☐ No ☐ Yes - Indicate Employer Name ____
- *Internal Use Only: IP indicate corresponding Non-Centralized Code* ________________
- Are you currently deferring to more than one Investment Provider? ☐ No ☐ Yes-Indicate amount per pay period? _________________

NOTE- If you choose more than one investment provider, you must do either $ or % across all providers. If a participant elects to contribute % of salary as opposed to a $ amount, the % cannot exceed 80%.

☐ **Check here if you want your deferrals increased every January** Amount: **$**_________**OR** ____**%** of gross salary per pay period

☐ **Check here if you want to contribute the maximum deferrals annually.**

A. Deferral Request- Unless a future deferral request is indicated below, this deferral request will be effective until a change is submitted.
Effective Salary Warrant Date ________/ _______/ _______ Amount: **$**_________**OR** __ __ **%** of gross salary per pay period.

B. Future Deferral Request
Effective Salary Warrant Date _______/ _______/ _______ Amount: **$**___________ **OR** __ __ **%** of gross salary per pay period.

For internal use only – Pay Cycle: 08-04=B68, 08-05=B69, 08-06=B70, 09-04=B71, 09-05=B72, 09-06 = B73, 10-06=B74, 10-07=B75

Section 3- BENEFICIARY DESIGNATION (If more space is needed please attach an additional Participant Action Form)

In the event of my death, the balance of my account shall be paid to the Primary Beneficiary(ies) who survive me in the specified percentages. If any Primary Beneficiary(ies) does not survive me, that portion of the balance of my account will be paid to the surviving Primary Beneficiaries in amounts consistent with the percentages indicated. If no Primary Beneficiary(ies) survives me, then the balance of my account is paid to the surviving Contingent Beneficiary(ies) in the specified percentages. If no Beneficiary(ies) survives me, the balance of my account shall be paid to my Estate. **NOTE:** Contingent Beneficiaries are optional: Also, Primary Beneficiaries must total 100% and Contingent Beneficiaries must total 100.

☐ Primary **OR** ☐ Contingent Spouse? ☐ No ☐ Yes Date of Birth: _____ / _____ / _____ % of Account __ __ __
Name (First, MI, Last) ____ SSN ________________________________
Address: ____ City: _______________________ State: _____ Zip: __________

☐ Primary **OR** ☐ Contingent Spouse? ☐ No ☐ Yes Date of Birth: _____ / _____ / _____ % of Account __ __ __
Name (First, MI, Last) ____ SSN ________________________
Address: ____ City: _______________________ State: _____ Zip: __________

☐ Primary **OR** ☐ Contingent Spouse? ☐ No ☐ Yes Date of Birth: _____ / _____ / _____ % of Account __ __ __
Name (First, MI, Last) ____ SSN _____________________________
Address: ____ City: _______________________ State: _____ Zip: __________

I agree to all terms and conditions of the State of Florida Deferred Compensation Plan. I hereby authorize the State Comptroller to deduct from my salary the amount(s) specified above and State Office of Deferred Compensation to transmit the deduction to the above named investment provider. This authorization will continue until my provider submits to the State a request for a suspension or change in my deferral before the appropriate deadlines. **Deferral changes (increases, decreases, and suspensions) can not be effective in the same month that the request is made unless it is a new employee enrolling for the first time.** Ultimately, it is my responsibility to ensure that the amounts of my annual combined contributions to these programs are not in excess of the current maximums. I am solely responsible for any investment gains and/or losses, other losses and all charges and expenses associated with my participation in the plan. I understand that the State of Florida does not represent, nor guarantee, that any particular tax consequences will occur due to my participation in the plan. I must consult my own accountant, attorney, or other representative for personal consultation regarding tax and investment consequences arising from my participation in the plan.

I WILL IMMEDIATELY CONTACT MY INVESTMENT PROVIDER (S) WHEN I SEPARATE FROM STATE EMPLOYMENT.

_______________________________________ _______________________________________
Participant Signature Date State Office or other Authorized Signature Date

_______________________________________ _______________________________________
Deferred Compensation Specialist Signature Date Deferred Compensation Specialist (Print Name)