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 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 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: __________________

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- Deferral Mode ($ or %) must be the same among all Investment Providers. System limitations allow a maximum deferral of 80.00%.

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) survive 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: _________

☐ 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. **Requests for new enrollments, deferral increases, decreases, and suspensions must be received by my investment provider fourteen (14) weekdays prior to the effective warrant date. Requests received after the deadline will be processed for the next available warrant date.** 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)

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