DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF TREASURY – BUREAU OF DEFERRED COMPENSATION

STATE OF FLORIDA DEFERRED COMPENSATION PLAN

COMPANY TO COMPANY TRANSFER

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

OLD Investment Provider: ☐☐☐ ***NEW 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: _____

***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.**

NOTE: I understand that there are no fees for transferring my balance from one Investment Provider to another unless the transfer involves Certificates of Deposit (CDs) that may impose an early withdrawal penalty. **READ AND INITIAL: _____**

Do you have an outstanding Deferred Compensation loan obligation with the old Investment Provider? ☐ Yes ☐ No
If yes, additional information may be required to complete your company to company transfer.

Section 2 - REQUESTED ACTION (*INITIAL one box only*)

☐ **Transfer/Replacement -** I would like to stop (or decrease) my deferrals to the old investment provider listed above, and begin (or increase) deferring to the new investment provider listed above. In addition, I request that all, or a portion of, my funds be transferred from my old investment provider to my new investment provider (Specify transfer information in section 2 below. Attach a Participant Action Form with deferral replacement information indicated**).**

☐ **Transfer Only -** I would only like to transfer all, or a portion of, my funds from the old investment provider listed above to the new investment provider listed above**,** with which I have already enrolled **(Specify transfer information in section 2 below).**

Section 3 - TRANSFER TOTAL(S) AND INVESTMENT OF TRANSFERRED AMOUNT(S) (*Select 1 Option Only*)

1. I am requesting that ☐**ALL or** ☐☐☐ **% or $**☐☐☐**,** ☐☐☐**.**☐☐ of my account value be transferred
from_____ **to** _____
(**old investment provider**) (**new investment provider**)

If you are only transferring a portion of your balance, indicate which investment product(s) the funds should be transferred out of:

_____ ☐☐☐ **%** _____ ☐☐☐ **%** _____ ☐☐☐**%**
_____ ☐☐☐ **%** _____ ☐☐☐ **%** _____ ☐☐☐**%**

2. How would you like this transferred money to be invested upon receipt by the new investment provider? (You must have received and read a prospectus for each investment product):

_____ ☐☐☐ **%** _____ ☐☐☐ **%** _____ ☐☐☐**%**
_____ ☐☐☐ **%** _____ ☐☐☐ **%** _____ ☐☐☐**%**

Investment Provider Comparative Information

The State of Florida, Bureau of Deferred Compensation publishes information that would allow you to uniformly compare all companies approved to market their products to State employees. This quarterly document, ***"The Performance Report"***, includes quarterly performance returns for each company's product, as well as a disclosure of all current fees assessed by each company.
You may contact the State Office at SUNCOM 293-3162 or 1-877-299-8002 or via the Internet at www.myfloridadeferredcomp.com to obtain a copy of the Performance Report.

My signature reflects that I understand and have accurately completed this form, and request, that my above instructions be completed by the State and the appropriate companies. I understand that the Deferred Compensation Specialist representing the new investment provider is responsible for submitting this document to the State. The State will only upon receipt of properly completed paperwork, notify my old company of my desire to either transfer funds and/or stop my deferral.

_____ _____
Participant Signature Date State Office Signature Date

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