



**DEPARTMENT OF FINANCIAL SERVICES**  
**Division of Treasury – Bureau of Deferred Compensation**

**STATE OF FLORIDA DEFERRED COMPENSATION PLAN**

**PARTICIPANT ACTION FORM**

**Investment Provider**

<p><b>Requested Action</b></p> <input type="checkbox"/> Enrollment <input type="checkbox"/> Increase Deferral <input type="checkbox"/> Decrease Deferral <input type="checkbox"/> Stop Deferral <input type="checkbox"/> Address/email/Phone Number Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Pay Cycle Change <input type="checkbox"/> From Biweekly to Monthly <input type="checkbox"/> From Monthly to Biweekly <input type="checkbox"/> Name Change From: _____ _____	<p><b>Replacement Information for Company to Company Transfers</b> (attach form)</p> <input type="checkbox"/> Stop Deferral with: _____ <input type="checkbox"/> Decrease Deferral with: _____ to \$ _____ <b>OR</b> _____ . _____ % per pay period
<input type="checkbox"/> Special Instructions: _____	<p><b>Deferral From Special Supplemental Payroll</b> (attach form) (leave Section 2 blank)</p> <input type="checkbox"/> Accrued Leave <b>OR</b> <input type="checkbox"/> Other (ie: Merit or Retroactive) <input type="checkbox"/> Defer Maximum <b>OR</b> <input type="checkbox"/> Defer Up To \$ _____ <input type="checkbox"/> Entering DROP
	<p><b>“Catch-Up” Provision</b> (Cannot do Standard and 50 + in the same calendar year)</p> <input type="checkbox"/> 50 + Catch- Up <b>OR</b> <input type="checkbox"/> Standard Catch Up <input type="checkbox"/> Indicator already set <input type="checkbox"/> 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.

<input type="checkbox"/> Primary <b>OR</b> <input type="checkbox"/> Contingent Spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Birth: ____/____/____ % of Account ____ . ____ % Name (First, MI, Last) _____ SSN _____ Address: _____ City: _____ State: _____ Zip: _____
<input type="checkbox"/> Primary <b>OR</b> <input type="checkbox"/> Contingent Spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Birth: ____/____/____ % of Account ____ . ____ % Name (First, MI, Last) _____ SSN _____ Address: _____ City: _____ State: _____ Zip: _____
<input type="checkbox"/> Primary <b>OR</b> <input type="checkbox"/> Contingent Spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Birth: ____/____/____ % of Account ____ . ____ % Name (First, MI, Last) _____ SSN _____ Address: _____ City: _____ State: _____ Zip: _____
<input type="checkbox"/> Primary <b>OR</b> <input type="checkbox"/> Contingent Spouse? <input type="checkbox"/> No <input type="checkbox"/> 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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