DEPARTMENT OF FINANCIAL SERVICES
Division of Treasury – Bureau of Deferred Compensation
STATE OF FLORIDA DEFERRED COMPENSATION PLAN

ROTH PARTICIPANT ACTION FORM

Investment Provider: __________

Requested Action	**Replacement Information for Company to Company Transfers** (attach form)
☐ Enrollment in Deferred Compensation ☐ Increase **ROTH** Deferral ☐ Decrease **ROTH** Deferral ☐ Stop **ROTH** Deferral ☐ Address/Email/Phone Number Change ☐ Deferred Compensation Beneficiary Change ☐ Pay Cycle/Center Change ☐ From Biweekly to Monthly ☐ From Monthly to Biweekly ☐ Name Change From: __________________ ☐ Special Instructions: ______________________	☐ Stop **ROTH** Deferral with: _________ ☐ Decrease **ROTH** 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

*** Disclosure of your social security number or taxpayer identification number is mandatory. 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. Your social security number is confidential and exempt from the disclosure requirements of section 119.07(1) F.S., and section 24(a), Article I of the Florida Constitution and will not be used for any purpose of than the purpose(s) provided herein, or as otherwise authorized under section 119.071(5)(a), F.S.**

Section 2-PAYCYCLE/DEFERRAL INFORMATION

Pay-Cycle: ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Semi-Monthly Employer Name ___________________________________

- Are you paid on a Seasonal Pay schedule?: ☐ No ☐ Yes – Indicate valid pay months: From ___________ to __________
- *Internal Use Only: IP indicate corresponding Non-Centralized Code* ________________

NOTE- If a participant selects more than one investment provider for their ROTH deferral, they must do either $ or % for their ROTH deferrals across all providers. If a participant elects to contribute a % of salary as opposed to a $ amount, the total 457b contribution (ROTH and Pre-Tax) cannot exceed 80%. Participants may choose to make a ROTH deferral as a % of salary or a $ amount.

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.

Section 3 – Select a Beneficiary Designation for your Deferred Compensation Plan account.

In the event of my death, the balance of my account shall be paid to the Primary Beneficiary(ies) in the specified percentages who survive me. If no Beneficiary(ies) survives me, the balance of my account shall be paid to my Estate. Primary Beneficiaries must total 100% and Contingent Beneficiaries must total 100%. This election applies to your **Pre-Tax and Roth contributions** for the selected Investment Provider.

☐ 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: __________

By signing below, I agree to all terms and conditions of the State of Florida Deferred Compensation Plan. I hereby authorize this deduction from my salary in 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 I submit to the State a request for a suspension or change in my deferral before the appropriate deadlines. 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 NOTIFY 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)