DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF TREASURY – BUREAU OF DEFERRED COMPENSATION

STATE OF FLORIDA DEFERRED COMPENSATION PLAN

ROTH DEFERRALS FROM SUPPLEMENTAL PAY

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: _____

***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.**

PARTICIPANT (EMPLOYEE) READ CAREFULLY

- **Roth 457b contributions are subject to Federal Income Tax.** Your entire Roth supplemental payment will be subject to Federal Income, Social Security and Medicare taxes. The remainder of the Roth supplemental payment will be sent to your investment provider as a Roth (Post-Tax) deferral.

- **You may also defer a portion of your Supplemental Payment as a Pre-Tax 457b.** To additionally contribute to your Pre-Tax 457 account, you must also complete a Deferral for Special Supplemental Pay Form, DFS-J3-1173, and Participant Action Form, DFS-J3-1163, for the 457b portion.

- **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 AND YOUR INVESTMENT PROVIDER COMPANY.

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 follow the directions above 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)