



DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF TREASURY – BUREAU OF DEFERRED COMPENSATION

STATE OF FLORIDA DEFERRED COMPENSATION PLAN

**DEFERRALS FROM SPECIAL
 SUPPLEMENTAL PAY**

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

Investment Provider: GWR

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: _____

*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.

PARTICIPANT (EMPLOYEE) READ CAREFULLY

- **You will not be able to defer all of your special supplemental payment.** Your entire supplemental payment will be taxed for Social Security and Medicare. Social Security and Medicare amounts are subject to Federal Income (withholding) tax. The State Payroll System uses a formula that calculates the maximum possible deferral. The amount deferred will not be subject to Federal Income Tax. **Due to manual calculations and processing, a small amount may be made payable to you after the deferred compensation deferral is sent to your investment provider company.**
- **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.**
- **DO NOT GIVE PARTICIPANT ACTION FORMS TO YOUR PERSONNEL/PAYROLL OFFICE.**
- **RETURN THE STATE AND INVESTMENT PROVIDER FORM COPIES TO THE INVESTMENT PROVIDER COMPANY FOR PROCESSING.**

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 do so 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)