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

STATE OF FLORIDA DEFERRED COMPENSATION PLAN **REQUEST FOR DISTRIBUTION**

Please print clearly in ballpoint pen, and press firmly to ensure that all copies are completed. Initial any corrections or changes.

Investment Provider: NRS

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: _____

Do you have an outstanding Deferred Compensation loan? ☐NO ☐YES

***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 - REQUEST FOR DISTRIBUTION DUE TO: **Month Day Year**

☐Separation from Service Agency/Department _____ Last Official Work Day ☐☐/☐☐/☐☐

This can be verified by calling my personnel office: Phone # _____

NOTE: Failure to submit last official work day, Agency and phone # WILL DELAY the distribution process.

☐Death _____ ☐☐☐-☐☐-☐☐☐☐ _____% **(IP Use Only)**
Beneficiary Name **Beneficiary SS Number**

☐De Minimus (Allowed only after 2 years (or more) with no contributions to deferred compensation and total account value less than $5,000 with all investment providers.) **FOR IP USE ONLY** - Last Deferral Date **_____.**

☐In Service Distribution (available only for participants older than **70 ½** and still employed by the State of Florida)

☐Health & Long Term Care Insurance (limited to $3000 annually)

☐RMD (Required Minimum Distribution)

☐QDRO (Qualified Domestic Relation Order**) Participant's Name** _____ **SSN**_____

FOR IP USE ONLY: Contribution Amt: $_____ SECTION 2 INFORMATION VERIFIED BY _____

READ THIS INFORMATION COMPLETELY

- By State Law, separation from service occurs 31 days after your last official work day.
- Distributions from your account must begin no later than the calendar year that you will turn **70 ½** years of age, unless you are still employed with the State of Florida.
- Any scheduled distributions under 10 years duration will be subject to a Federal Withholding Tax of 20%. (Including any type of lump sum)

_____ (Please initial) **I have received the tax information provided by my investment provider company**

_____ (Please initial) I am requesting that my account balance be distributed to me according to the method elected below.

_____ (Please initial) I am requesting a change to my payout method as indicated below.

_____ (Please initial) I am requesting to stop my distribution.

Section 3 - Distribution Options **Requested date for distribution to begin _____ (month/year)**

1) ☐Lump Sum Payment of entire account balance.
2) ☐Partial Lump Sum Payment……..Amount $_____
3) ☐Fixed Dollar Payment……..Amount $_____
(specified amount per payment until account balance reaches zero)
☐Include Cost of Living Adjustment (COLA)
4) ☐Fixed Period Payment……_____years
(account balance is paid to your over the number of years specified)
☐Include Cost of Living Adjustment (COLA)
Method One: Recalculates amount with each payment
Method Two: Recalculates payment amount annually
5) ☐Required Minimum Distribution (Must be at least age 70 ½)
6) ☐ Lifetime/Joint Lifetime Payment (payment amount is recalculated annually based on life or joint life expectancy at time of calculation)
☐ Lifetime
☐ Joint Lifetime (beneficiary's date of birth: _____

Purchased Annuities
7) ☐ Life Income
8) ☐ Life Income With Payment Certain
☐ 5 yrs certain ☐ 10 yrs certain ☐ 15 yrs certain
☐ 20 yrs certain ☐ 25 yrs certain ☐ 30 yrs certain
9) ☐ Joint and Last Survivor Life Income
☐ 50% ☐ 66 2/3% ☐ 75% ☐ 100%
10) ☐ Purchased Designated Amount
Indicate amount: $_____
11) ☐ Purchased Designate Period (1-30 years)
Indicate number of years: _____years

NOTE: A W-4P is required for all payouts. The minimum monthly payment for all payout options is $25, including Required Minimum Distribution (option 5). If you are requesting distributions as a beneficiary, you must submit an official death certificate.

Payment Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

_____ _____
Participant Signature Date State Office or other Authorized Signature Date

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