COLLEGE of CENTRAL FLORIDA
–an equal opportunity college–

PARTICIPATION AGREEMENT/DEFERRAL ELECTION
SECTION 457(b) DEFERRED COMPENSATION PLAN

Participant Information

Plan Name: _____ **Billing Group No.:** _____

Department Name: _____ **Department Location:** _____
City State

Legal Name: _____
Last First Middle (complete) Jr., etc.

Birth Date: _____ **CF ID No.:** _____
MM/DD/YY

Mailing Address: _____
Street/P.O. Box City State Zip Code

Telephone No.: _____ **Work Telephone No.:** _____

New Participant Agreement to be completed by NEW plan participants only.

Salary Reduction Per Pay % or $ _____

Number of Pay Periods Per Year (if $ then multiply) X _____

Annual Contribution % or $ _____

Contribution Rate Change to be completed by EXISTING plan participants only.

☐ Increase ☐ Decrease

Indicate the current amount being deducted from your pay: % or $ _____

Indicate the new amount you wish to have deducted from your pay: % or $ _____

Effective Date

This agreement will be effective upon receipt and processing by the employer. If you would like to choose a later effective date, indicate below. **NOTE: It may take several payroll cycles for your payroll office to process this agreement.**

_____
Date: MM/DD/YY

Catch-up Contribution Eligibility

Are you within three years prior to the year of normal retirement age? ◯ Yes ◯ No

Does this plan provide for the Older Worker Catch-up Provision allowed under Internal Revenue Code Section 414(v)?

◯ Yes ◯ No

A participant cannot simultaneously contribute under the 457 Special Catch-up and the Older Worker Catch-up.

This agreement is made between the participant (as indicated below) and the employer in conjunction with the deferred compensation plan established and maintained by the employer. The elections indicated above will remain effective until later changed or revoked by the participant.

I hereby elect to participate in my employer's 457 Deferred Compensation Plan and adopt the provisions of the plan. I hereby acknowledge that I have received a copy of the plan document, where applicable.

I acknowledge that I am responsible for determining that the amount of compensation I defer does not exceed the limits set forth in Sections 457 and 414(v) of the Internal Revenue Code, as amended.

By signing this form, I certify that the information I provided is complete and accurate.

Please return form to the address above. This form will be forwarded to your Payroll Office.

_____ _____
Participant Signature Date: MM/DD/YY