FLORIDA ATLANTIC UNIVERSITY

Request for Termination of Deferred Pay Option Plan

NAME_____
LAST FIRST INITIAL

EMPLOYEE Z - NUMBER_____
(Located at top of pay stub after name)

___9 Month Employee
___10 Month Employee

I hereby request to terminate participation in the Deferred Pay Option Plan effective _____. I understand that:

- My gross salary will be recalculated to reflect this termination according to the standard payroll schedule.
- I will not be allowed to enroll in the Deferred Pay Option Plan until the next academic year.

I hereby certify and agree to all provisions of this termination.

_____ _____
Employee Signature Date

Please return completed form to:
Department of Human Resources
Processing and Records
IS-4, Room 237

****HUMAN RESOURCES USE ONLY****

Department	Input Date	Input Initials
Processing & Records		
Payroll		