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:
mm/dd/yyyy

- 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 Personnel Services
Processing and Records
Administration Building Room 109

****PERSONNEL SERVICES USE ONLY****

Department	Input Date	Input Initials
Processing & Records		
Benefits & Retirement		
Payroll		