# FLORIDA ATLANTIC UNIVERSITY
## Authorization for
## Deferred Pay Option Plan

NAME_____
LAST First Middle Initial

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

- ❑ 9 Month Employee
- ❑ 10 Month Employee

I, hereby authorize the allocation of my salary equally over the 12-month period starting August of every year. I understand that:

- My gross salary will be disbursed to me equally over the 12-month period of the academic year according to the standard payroll schedule.
- My salary deductions will be processed over 12 months.
- I will not be allowed to revoke this election during an academic year.
- My participation in the Deferred Pay Option Plan will automatically continue each academic year until cancelled by submission of a ***Request for Termination of Deferred Pay Option Plan*** form.
- Cancellation of participation in the plan for the next academic year must be submitted to the Department of Human Resources before June 30th of the current academic year.
- If I retire or resign from my position at the end of the academic year, I can elect to stay in the deferred pay plan until the end of the cycle in August.
- If I retire or resign from my position before the end of the academic year, the deferral process ends and all monies that have been set aside for payout during the summer months will be paid in full.
- In the event of my death, the money accumulated in the deferred pay account will be paid to my designated beneficiary.

I hereby certify and agree to all provisions of the Deferred Pay Option Plan.

_____ _____
Employee Signature Date

Please return completed form to:
Department of Human Resources
Processing and Records
Administration Building Room 109

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

| Department | Input Date | Input Initials |
|---|---|---|
| Processing & Records | | |
| Benefits & Retirement | | |