



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 Personnel Services before June 30th of the current academic year.
- If I retire or resign from my position, 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 Personnel Services
 Processing and Records
 Administration Building Room 109

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

Department	Input Date	Input Initials
Processing & Records		
Benefits & Retirement		