



**SECTION I**

Name: \_\_\_\_\_  
(Last name) (First name) (Middle initial)

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_  
mm/dd/yyyy

**SECTION II I WANT TO BE AN FRS MEMBER**

I am a new member and will complete the Form ELE-1 or Form ELE-1-EZ as appropriate. Proceed To Section IV – Signature

I am an existing FRS member and want to retain my participation in the FRS. Proceed To Section IV - Signature

**SECTION III I WANT TO BE A SUSORP MEMBER**

I am a new member and wish to enroll in the SUSORP.

I am an existing SUSORP member and want to retain my participation in the SUSORP.

**As a SUSORP member, I understand that:**

1. It is my responsibility to ensure that my tax-deferred income deductions do not exceed the maximum amount set in the Internal Revenue Service Code and Regulations.
2. I may choose to have up to 5.14% of my adjusted gross taxable salary deducted as my Voluntary Employee Contribution; however, (a) I must be under the maximum exclusion allowance and (b) my adjusted gross income minus any payroll deductions (e.g., credit union, or 457 plan), must be sufficient to cover the Voluntary Employee Contribution.

**I elect the following:**

Provider Company	<u>Required Employer and Employee Contributions</u> The total employer contribution is 5.14%. I choose to allocate contributions to one or more provider companies as indicated below. My 3% required employee contribution will also be allocated at the same ratio.	<u>Voluntary Employee Contribution</u> (Total percentage must not exceed 5.14% of your salary)
MetLife Investors	%	%
TIAA-CREF	%	%
VALIC	%	%
Jefferson National	%	%
ING	%	%
<b>Total _____</b> <b>(Must equal 5.14%)</b>		<b>Total _____</b> <b>(Must not exceed 5.14%)</b>

**SECTION IV SIGNATURE**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION V TO BE COMPLETED BY EMPLOYER:**

Agency Name: \_\_\_\_\_ Agency Number: \_\_\_\_\_

Class Code: \_\_\_\_\_ Position Number: \_\_\_\_\_

Position Title: \_\_\_\_\_

Date of Employment in SUSORP Eligible Position: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**I certify that the above information is correct and this member is employed in a SUSORP-eligible position and has executed a contract(s) with the SUSORP provider(s) elected above.**

\_\_\_\_\_  
Authorized Personnel Signature

\_\_\_\_\_  
Date