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.
- 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
IS-4, Room 237

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

Department	Input Date	Input Initials
Processing & Records		
Payroll		