

Florida Retirement System
State University System Optional Retirement Program (SUSORP)/FRS Ballot



2639 N. Monroe St., Bldg. C
Tallahassee, FL 32399-1560

TO BE COMPLETED BY EMPLOYEE (Please Type or Print)

Member SSN : _____

Member Name: _____

Tape Copy of Social Security Card Here

Prior Name: _____

Birthdate: _____ Gender _____

In lieu of participating in the ORP, I elect to participate in the FRS .

Member Signature: _____ Date: _____

Faculty members employed at the J. Hillis Miller Health Center at the University of Florida or the Medical Center at the University of South Florida must remain in the ORP.

I elect to become a member of the ORP and have signed necessary contracts since my employment with the University, as follows:

Employer's % (Must Equal 10.32% of Salary*)	Employee's % (Cannot Exceed 10.32% of Salary*) See No. 3 Below	Name of Company
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total _____%

Total _____%

I Understand That:

- I cannot participate in the ORP if I am a retiree of the FRS, SCOERS or TRS or receiving an annuity payment from the Florida ORP.
- Prior membership in the FRS is inactivated on the effective date of ORP enrollment and this election is irrevocable.
- It is my responsibility to assure that my tax deferred income deductions do not exceed the maximum amount set in the Internal Revenue Service Code and Regulations.
- *4. If my maximum exclusion allowance allows it and I choose to have up to 10.32% of my adjusted gross taxable salary deducted as an employee contribution to my plan, my adjusted gross income minus any payroll deductions, such as to a credit union, the 457 plan, or other, must be sufficient to cover this personal ORP deduction. My employer contributions shall be based upon my total unadjusted gross salary.
- The State of Florida does not guarantee nor insure the benefits paid under this program.
- I certify that I have signed a Florida ORP contract.

Member Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

Employing Agency: _____ Agency Number: _____

Class Code: _____ Pos. No. (A&P Only): _____ Class Title: _____ Date of this Employment: ___/___/___

I certify that since their employment with the University, this employee has signed a contract(s) with the ORP carrier(s) as shown and is filling an eligible position.

Reason for Submitting This form – Check Below

Signature of University Personnel Officer _____ Date _____

- Enrollment
- Company Change
- Name Change
- Contributions Change
- J. Hillis Miller Health Center
- Medical Center at the University of South Florida
- Other