FMPTF 401(a) Defined Contribution and 457(b) Deferred Compensation
INFORMATION CHANGE FORM

Please turn this form into your Human Resources department. If you would like to change the information, please fill out the appropriate area. If there is an area that you do not need to change information, leave that section blank.

1. Participant Identification Information (YOU MUST FILL THIS SECTION OUT)

Participant's Name: _____ Social Security No. _____

Employer: _____

2. New Contact Information (optional – fill out if your contact information has changed)

Street Address: _____ Phone Number: _____

City, State Zip: _____ Birth Date: _____

3. 457(b) Deferral Amount (optional – fill out if you are changing your deferral amount)

Effective Date: _____ * Cannot exceed IRC Limits

Salary Reduction per pay: _____ % or $ _____ x _____ # of Pays = EE Annual Contributions $ _____*

Age 50 catch-up contribution: $ _____ x _____ # of Pays = EE Catch-up Contributions $ _____*

Pre-retirement catch-up contribution: $ _____ **

** Cannot exceed IRC Limits. You must also complete the 457 Catch-up Form

4. Beneficiary Designation (optional – fill out if you are changing your beneficiary)

This designation revokes any previous beneficiary designation for this Plan. Unless you specify otherwise, if you designate more than one beneficiary in any one class, the beneficiaries in the class will share equally. This will be effective for both FMPTF 401(a) and 457(b) plans unless specified differently below.

Applies to which plan(s): ☐ **Both** ☐ **Just 401(a)** ☐ **Just 457(b)**

Primary Beneficiary(ies): *If more than two(2), attach additional sheets and check here* ☐

(1) Name: _____ Relationship: _____

Social Security Number or TIN_____ Percentage: _____

(2) Name: _____ Relationship: _____

Social Security Number or TIN_____ Percentage: _____

Contingent Beneficiary(ies):

(1) Name: _____ Relationship: _____

Social Security Number or TIN_____ Percentage: _____

(2) Name: _____ Relationship: _____

Social Security Number or TIN_____ Percentage: _____

(3) Name: _____ Relationship: _____

Social Security Number or TIN_____ Percentage: _____

(4) Name: _____ Relationship: _____

Social Security Number or TIN_____ Percentage: _____

PARTICIPANT – PLEASE SEND BOTH PAGES OF THE FORM TO THE EMPLOYER

_____ _____

Participant Signature Date

5. Employer Sign-off

Employer, please retain a copy for your records and send a copy to the FMPTF.

_____ _____

Employer Signature Date

_____

Name/Title

Employer: please fax paperwork to 850-222-3806 (ATTN: DC Program) or mail to:

FMPTF c/o DC Program
PO Box 1757
Tallahassee, FL 32302-1757