State University System Optional Retirement Program (SUSORP)
Retirement Plan Enrollment

PO Box 9000 Tallahassee, FL 32315-9000
Toll Free: 877-378-7677 Local: 850-778-4696 Fax: 850-410-2196

SECTION I

Name: ______________________ (Last name) ______________________ (First name) ________ (Middle initial)

Social Security Number: ________________ Birth Date: ____________ (mm/dd/yyyy) Gender: Male ___ Female ____

Email Address: ______________________ Telephone Number ______________________

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	**Required Employer and Employee Contributions** 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.	**Voluntary Employee Contribution** (Total percentage must not exceed 5.14% of your salary)
MetLife Investors ORP	%	%
TIAA ORP	%	%
AIG ORP	%	%
VOYA ORP	%	%
Equitable ORP	%	%
	Total ________ **(Must equal 5.14%)**	**Total** ________ **(Must not exceed 5.14%)**

SECTION IV MEMBER: PLEASE SIGN AND SUBMIT THIS FORM TO YOUR EMPLOYER

Member Signature: ______________________ Date: ______________

SECTION V EMPLOYER: PLEASE COMPLETE INFORMATION BELOW AND SUBMIT TO THE DIVISION

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