FLORIDA 529 SAVINGS PLAN

STATE OF FLORIDA PAYROLL DEDUCTION AUTHORIZATION FORM

To request payroll deduction for the Florida 529 Savings Plan, please complete, sign, and return this form to your **Post-Tax Benefits Office** for processing. For assistance, contact Florida Prepaid at 1-800-552-4723.

IMPORTANT! Before you request payroll deduction for the Florida 529 Savings Plan, the beneficiary (student) must have an account. This form is not an enrollment application. You may enroll online at www.myfloridaprepaid.com or call 1-800-552-4723 for an enrollment kit and application. Once your enrollment application has been processed, you will receive a confirmation package from the program with the account numbers necessary to complete this form.

EMPLOYEE'S FIRST/LAST NAME

( ) _____- _____
EMPLOYEE'S WORK NUMBER

( ) _____- _____
EMPLOYEE'S HOME/CELL NUMBER

☐☐☐☐☐☐☐☐
EMPLOYEE'S PEOPLE FIRST ID NUMBER

☐☐☐ ☐☐ ☐☐☐☐

☐☐☐– ☐☐– ☐☐☐☐
ACCOUNT OWNER SOCIAL SECURITY NUMBER

PAY CYCLE

❑ Monthly (12)

MONTHLY DEDUCTION AMOUNT:

$ ☐☐☐.☐☐

	BENEFICIARY'S SOCIAL SECURITY NUMBER	PERCENTAGE AMOUNT(S)
1ST BENEFICIARY'S FIRST/LAST NAME	☐☐☐–☐☐–☐☐☐☐	%
2ND BENEFICIARY'S FIRST/LAST NAME	☐☐☐–☐☐–☐☐☐☐	%
3RD BENEFICIARY'S FIRST/LAST NAME	☐☐☐–☐☐–☐☐☐☐	%
4TH BENEFICIARY'S FIRST/LAST NAME	☐☐☐–☐☐–☐☐☐☐	%

PERCENTAGE MUST TOTAL **100%**

I authorize my employer to deduct from my bi-weekly paycheck the total deduction amount for the Florida College Investment Plan account(s) listed above. I understand that I may cancel or change my payroll deduction at any time. If I cancel my payroll Deduction, terminate from employment, or if for any reason the deduction is not made by my employer as scheduled, I understand that I must submit my contribution(s) for the above account(s) directly to the Florida College Investment Plan.

EMPLOYEE'S SIGNATURE _____ **DATE** _____

RETURN THIS FORM TO YOUR POST TAX BENEFITS OFFICE.

To be completed by Post-Tax Benefits Coordinator

Payroll Deduction Code: 0267

*Effective Warrant Date: _____

Department: _____

Date Initiated: _____ Telephone: _____

Print Name: _____

*ALLOW AT LEAST TWO WEEKS FOR PROCESSING.

PERSONNEL MUST SUBMIT A COPY OF THIS COMPLETED FORM TO:

FLORIDA COLLEGE INVESTMENT PLAN
P.O. BOX 6567 TALLAHASSEE, FL 32314-6567
FAX 850-309-1766
EMAIL: PayrollDeduction@florida529plans.com