ORP-MAND–1
Effective 11/15
Enrollment

State University System Optional Retirement Program (SUSORP)
Mandatory Participation Form

PO Box 9000, Tallahassee, FL 32315-9000
Toll Free: 844-377-1888 Local: 850-907-6500 Fax: 850-410-2196

Per paragraph 121.051(1)(a), Florida Statutes, any person appointed to a faculty position, including clinical faculty, in a college at a state university that has a faculty practice plan may not participate in the Florida Retirement System and is a mandatory member of the State University Optional Retirement Program (SUSORP) for the State University System.

Name: _____ _____ _____
(Last name) (First name) (Middle initial)

Social Security Number: _____ Birth Date: _____ Gender: Male ___ Female ____
mm/dd/yyyy

Email Address: _____ Telephone Number: _____

As a mandatory participating SUSORP member, 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-CREF ORP	**%**	**%**
VALIC ORP	**%**	**%**
VOYA ORP	**%**	**%**
AXA ORP	**%**	**%**
	Total _____ (Must equal 5.14%)	**Total _____ (Must not exceed 5.14%)**

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.

MEMBER: PLEASE SIGN AND SUBMIT THIS FORM TO YOUR EMPLOYER

Member Signature: _____ Date: _____

EMPLOYER: PLEASE COMPLETE INFORMATION BELOW AND SUBMIT TO THE DIVISION

Agency Name: _____ Agency Number: _____

Class Code: _____ Position Number: _____

Position Title: _____

Date of Employment: _____ Effective Date: _____

I certify that the above information is correct and this member is employed in a Mandatory SUSORP position and has executed a contract(s) with the SUSORP provider(s) elected above.

_____ _____
Authorized Personnel Signature Date