

Southeastern Louisiana University
Faculty Deferred Pay Plan Form

Name: _____ WDID: _____

I request to participate in the Faculty Deferred Pay Plan and will receive my 9-month academic salary over 12-months

I understand: this is an irrevocable decision during the plan year

participation in the plan becomes effective at the beginning of the plan year

participation in the plan continues from year to year until the employer or university cancels participation in writing

to cancel my enrollment, I must submit a new form that will be effective at the end of the plan year (July 31st) and my salary will revert back to a standard distribution (10 checks) effective August 1st

by signing below I am enrolling in the Faculty Deferred Pay Plan and will receive my gross academic salary over a 12-month plan year from August 1st through July 31st

Signature: _____ Date: _____

PLEASE NOTE: This form must be received in Human Resources by August 15th of the plan year. Forms received after August 15th will be held for the next plan year.

Request for Cancellation of Authorization for Faculty Deferred Pay Plan

Name: _____ WDID _____

I request to cancel my participation in the Faculty Deferred Pay Plan and will begin receiving my 9-month academic salary as a standard disbursement of 10 checks from August 1st through May 31st

I understand: this request will be effective at the end of the plan year (July 31st)

this form must be received on or before August 15th to take effect in the current plan year

by signing below I am cancelling my participation in the Faculty Deferred Pay Plan and will receive my gross academic salary over the standard 9-month distribution (10 checks) from August 1st through May 31st

Signature: _____ Date: _____