

Review or update your beneficiary in the Florida Deferred Compensation Plan

You may have designated your beneficiary in the Florida Deferred Compensation Plan when you first enrolled or a long time ago. Now may be a good time to review and make any updates as necessary to your elections.

Consider taking these steps to help plan for the future from Corebridge Financial:



Designate a beneficiary: The beneficiary can be any individual, trust or estate — and you can name one person, several people or a combination of people and entities.



Keep your beneficiary designation current: Update it when there's a major change in your life — such as a marriage, new child, divorce or death.



Protect your family and make your preferences today. It takes just a few minutes — so don't delay!



Review or update your beneficiary in the Florida Deferred Compensation Plan



Designate or update your beneficiary using the Participant Action Form.

After completing the Participant Action Form, please send a copy to:

Corebridge Financial
Document Control
P.O. Box 15648
Amarillo, TX 79105-5648

You may also email valicstateoffldefcomp@aig.com or send by fax to 813.269.3338.

For additional information about your Florida Deferred Compensation Plan account, please contact one of our local and dedicated financial professionals at corebridgefinancial.com/rs/floridadcp/home/contact-us or the Client Care Center at 1.888.467.3726.

floridadcp.corebridgefinancial.com 1.888.467.3726

We're here to help you take action

You can reach out directly to your financial professional.

This material is general in nature, was developed for educational use only, and is not intended to provide financial, legal, fiduciary, accounting or tax advice, nor is it intended to make any recommendations. Applicable laws and regulations are complex and subject to change. Please consult with your financial professional regarding your situation. For legal, accounting or tax advice consult the appropriate professional.

Annuities are issued by **The Variable Annuity Life Insurance Company**, Houston, TX. Variable annuities are distributed by **AIG Capital Services, Inc.**, member FINRA.

Securities and investment advisory services offered through **VALIC Financial Advisors, Inc.**, member FINRA, SIPC and an SEC-registered investment adviser.

VALIC Retirement Services Company provides retirement plan recordkeeping and related services and is the transfer agent for certain affiliated variable investment options.

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**DEPARTMENT OF FINANCIAL SERVICES****Division of Treasury – Bureau of Deferred Compensation****STATE OF FLORIDA DEFERRED COMPENSATION PLAN****PARTICIPANT ACTION FORM****Investment Provider** (circle one)**Corebridge****Requested Action**

- ☐ Enrollment
☐ Increase Deferral
☐ Decrease Deferral
☐ Stop Deferral
☐ Address/Email/Phone Number Change
☒ Beneficiary Change
☐ Pay Cycle/Center Change
☐ From Biweekly to Monthly
☐ From Monthly to Biweekly
☐ Name Change From: _____
☐ Special Instructions: _____

Replacement Information for Company to Company Transfers (attach form)

- ☐ Stop Deferral with: _____
☐ Decrease Deferral with: _____ to \$ _____ OR _____ % per pay period

Deferral From Special Supplemental Payroll (attach form) (leave Section 2 blank)

- ☐ Accrued Leave OR ☐ Other (ie: Merit or Retroactive)
☐ Defer Maximum OR ☐ Defer Up To \$ _____
☐ Entering DROP

“Catch-Up” Provision (Cannot do Standard and 50 + in the same calendar year)

- ☐ 50 + Catch-Up OR ☐ Standard Catch Up
☐ Indicator already set
☐ Apply (Attach application)/Begin date: ____/____/____

Section 1-PARTICIPANT INFORMATION (Please CLEARLY PRINT NAME exactly as reported to your payroll office)

Name (First, MI, Last) [] SSN* [XXX-XX-]

Street Address: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

Phone Numbers: Home () Work () ☐ Male ☐ Female

*Your disclosure of your social security number or taxpayer identification number is required. Section 112.215 F.S. authorizes the creation of the State of Florida Deferred Compensation Plan, which is intended to qualify for tax deferral pursuant to 26 USC 457. Use of the identifying numbers is mandated by 26 USC 6109. Your social security number or taxpayer identification number will be used as an identifying number for purposes of federal tax law.

Section 2-PAYCYCLE/DEFERRAL INFORMATION**Pay-Cycle:** ☐ Monthly ☐ Bi-Weekly Annual Salary: _____

- Are you paid on a Seasonal Pay schedule?: ☐ No ☐ Yes – Indicate valid pay months: From _____ to _____
- Are you paid by a Non-Centralized Payroll Employer/University? ☐ No ☐ Yes - Indicate Employer Name _____
- Internal Use Only: IP indicate corresponding Non-Centralized Code _____
- Are you currently deferring to more than one Investment Provider? ☐ No ☐ Yes-Indicate amount per pay period? _____

NOTE- If you choose more than one investment provider, you must do either \$ or % across all providers. If a participant elects to contribute % of salary as opposed to a \$ amount, the % cannot exceed 80%.

☐ Check here if you want your deferrals increased every January Amount: \$ _____ OR _____ % of gross salary per pay period☐ Check here if you want to contribute the maximum deferrals annually.**A. Deferral Request-** Unless a future deferral request is indicated below, this deferral request will be effective until a change is submitted.

Effective Salary Warrant Date ____/____/____ Amount: \$ _____ OR _____ % of gross salary per pay period.

B. Future Deferral Request

Effective Salary Warrant Date ____/____/____ Amount: \$ _____ OR _____ % of gross salary per pay period.

*For internal use only – Pay Cycle: 08-04=B68, 08-05=B69, 08-06=B70, 09-04=B71, 09-05=B72, 09-06 = B73, 10-06=B74, 10-07=B75***Section 3- BENEFICIARY DESIGNATION (If more space is needed please attach an additional Participant Action Form)**

In the event of my death, the balance of my account shall be paid to the Primary Beneficiary(ies) who survive me in the specified percentages. If any Primary Beneficiary(ies) does not survive me, that portion of the balance of my account will be paid to the surviving Primary Beneficiaries in amounts consistent with the percentages indicated. If no Primary Beneficiary(ies) survives me, then the balance of my account is paid to the surviving Contingent Beneficiary(ies) in the specified percentages. If no Beneficiary(ies) survives me, the balance of my account shall be paid to my Estate. **NOTE:** Contingent Beneficiaries are optional: Also, Primary Beneficiaries must total 100% and Contingent Beneficiaries must total 100.

☐ Primary OR ☐ Contingent Spouse? ☐ No ☐ Yes Date of Birth: ____/____/____ % of Account ____

Name (First, MI, Last) _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Primary OR ☐ Contingent Spouse? ☐ No ☐ Yes Date of Birth: ____/____/____ % of Account ____

Name (First, MI, Last) _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Primary OR ☐ Contingent Spouse? ☐ No ☐ Yes Date of Birth: ____/____/____ % of Account ____

Name (First, MI, Last) _____

Address: _____ City: _____ State: _____ Zip: _____

I agree to all terms and conditions of the State of Florida Deferred Compensation Plan. I hereby authorize the State Comptroller to deduct from my salary the amount(s) specified above and State Office of Deferred Compensation to transmit the deduction to the above named investment provider. This authorization will continue until my provider submits to the State a request for a suspension or change in my deferral before the appropriate deadlines. **Deferral changes (increases, decreases, and suspensions) can not be effective in the same month that the request is made unless it is a new employee enrolling for the first time.** Ultimately, it is my responsibility to ensure that the amounts of my annual combined contributions to these programs are not in excess of the current maximums. I am solely responsible for any investment gains and/or losses, other losses and all charges and expenses associated with my participation in the plan. I understand that the State of Florida does not represent, nor guarantee, that any particular tax consequences will occur due to my participation in the plan. I must consult my own accountant, attorney, or other representative for personal consultation regarding tax and investment consequences arising from my participation in the plan.

I WILL IMMEDIATELY CONTACT MY INVESTMENT PROVIDER (S) WHEN I SEPARATE FROM STATE EMPLOYMENT.[] []
Participant Signature Date_____
State Office or other Authorized Signature Date_____
Deferred Compensation Specialist Signature Date_____
Deferred Compensation Specialist (Print Name)