

**This form must be received and date stamped in the Payroll Department  
 no later than 4:00 p.m., Monday, May 17, 2021.**

Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Employee Signature \_\_\_\_\_ Location \_\_\_\_\_

**DEFERRED COMPENSATION**

*Your employee contract allows you to participate in deferred compensation as follows:*

*Employees participating in the District approved Deferred Compensation Plan shall be eligible for a matching District contribution of \$1,500. The district match is the value of converted sick leave up to \$1,500 per year under the following conditions:*

*For each hour of accumulated sick leave in excess of 400 hours, the employee may elect to receive up to 100% of their current hourly rate of pay in match deferred compensation.*

As authorized by the applicable Employment Contract, I request that St. Francis Area Schools deduct the following number of hours to be transferred to the indicated Deferred Compensation Plan(s).

**ALL FORMS RECEIVED WILL BE PROCESSED AFTER July 1, 2021.**

Total unused SICK LEAVE hours	=	
Number of sick leave hours I need to be eligible to participate	-	400
Number of hours that are eligible for deferred compensation	=	
Number of hours I want to surrender to deferred compensation		
My hourly rate of pay	X	
Total dollars to be sent to Empower 403(b)	=	

***The dollar amount you defer must match and/or exceed the amount that you contributed to Empower through payroll deduction this year. The amount you defer cannot exceed \$1,500.***