



# PERAPlus 457 Plan Special or Sick/Annual Payment Deferral Form



Colorado Public Employees' Retirement Association  
Attn: Defined Contribution Team  
PO Box 5800, Denver, Colorado 80217-5800  
800-759-PERA (7372) • Fax: 303-863-3727 • copera.org

## Member SSN

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Complete this form if you would like to deduct PERAPlus 457 Plan contributions from a one-time payment of a special or sick/annual payroll payment. You may contribute a whole dollar amount, provided that amount does not exceed a yearly maximum set by the IRS. After completing the form, give it to your employer to complete the bottom portion before sending the form to PERA at the address above. The form must be received by PERA by the end of the month prior to the month in which the special or sick/annual pay is to be paid.

### Member Information

Name \_\_\_\_\_  
Last First MI  
Address \_\_\_\_\_  
Street City State ZIP Code  
Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_  
Email Address \_\_\_\_\_  
Sign up for electronic delivery of PERA information? Yes  No

### Deferral Information

One-Time Deferral Amount: \$ \_\_\_\_\_ OR  Defer All One-Time Pay  
Annual Salary: \$ \_\_\_\_\_  Roth (if applicable)  
 Pre-Tax

### Authorization

**I understand** that completing this form authorizes a one-time deferral amount to my PERAPlus 457 Plan account from my special or sick/annual pay.

**I understand** that completing this form will not change my normal monthly contribution amount. I understand that I may change my monthly contribution amount online by logging into my PERAPlus 457 Plan account.

**I understand** that my employer must complete the information below and this form must be received by PERA by the end of the month prior to the month in which the special or sick/annual pay is to be paid.

**I understand** that the deferral must occur within two and a half months from the date of separation from service, or the end of the calendar year that contains the separation from service, whichever is later.

**I understand** that it is my responsibility to monitor my total annual contributions to ensure that they do not exceed the maximum amount allowed by the IRS. I assume sole liability for any tax, penalty, or costs that may be incurred.

### Sign Here →

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

### To Be Completed by Employer

The employer must complete this section and update their payroll system accordingly for this one-time payment. The participant's deferral of record at Empower will not be changed and the employer will not receive a deferral feedback report for this participant's one-time payment request.

Date Form Received \_\_\_\_\_ Effective Pay Date \_\_\_\_\_

Employer Employer Number \_\_\_\_\_

Employer Payroll Personnel Name \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

### Sign Here →

Employer Payroll Personnel Signature \_\_\_\_\_ Date \_\_\_\_\_

