

New Orleans Regional Transit Authority

## Request for Cashout and Distribution of Frozen Vacation and/or PTO Hours

Name \_\_\_\_\_ Badge No. \_\_\_\_\_  
(please type)

In accordance with HC Policy 20, I hereby request a cashout of hours from my Sick Vacation bank, PTO account, or a combination, thereof.

### CHECKLIST ELIGIBILITY FOR PTO CASHOUT

Please select all of the following criteria that you meet.

☐ I have taken 40 hours of PTO for vacation purposes (TOV) in the last 24 months

☐ I have not received a PTO cashout in the past 12 months

☐ My PTO remaining balance will be 160 or more hours after my requested cashout

Current Balance

-Hours Cashout

Remaining Hours




I understand that the processing timeframe is approximately thirty days. I am requesting the cashout on or after the \_\_\_\_\_ pay date.  
(Pay date)

If you do not meet **ANY** of the above criteria, please complete Attachment 2 and submit both Attachment 1 and 2 to [humanresources@rtaforward.org](mailto:humanresources@rtaforward.org).

### CASHOUT

I hereby request my cashout as specified below. You **MUST** select one or both categories:

☐ Cashout of \_\_\_\_\_ hours from my Sick Vacation bank. The cashout will be payable at my regular rate of pay.

☐ Cashout of \_\_\_\_\_ hours from my PTO Account. The remaining balance must be 160 PTO hours or more. The cashout will be payable at my regular rate of pay.

### DISTRIBUTION

I hereby elect to receive my cashout of Sick Vacation and/or PTO hours, as specified below. You **MUST** select one or all three cashout options, if desired.

☐ \_\_\_\_\_ hours in **Cash Payment**. I understand that this option will result in applicable payroll-based taxes being withheld. For tax purposes, the government categorizes this cashout as Supplemental Wages, and it is taxable at the Federal flat rate of 22% and State flat rate of 6% rather than from the Tax Table. I understand that all other applicable taxes will be withheld at normal rates.

☐ \_\_\_\_\_ hours are to be deposited into my **457 Deferred Compensation Plan**. I understand that the **maximum deferral limitations** apply and that the minimum amount required is \$250.00.

☐

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete all items, sign the form, retain a copy for your records, then email to [humanresources@rtaforward.org](mailto:humanresources@rtaforward.org).

To Be Completed By Payroll

PR#: \_\_\_\_\_

Received by: \_\_\_\_\_

Date: \_\_\_\_\_

Processed by: \_\_\_\_\_

Date: \_\_\_\_\_