Florida Municipal Pension Trust Fund
Mailing address:
ATTN: Retirement Services
P.O. Box 1757
Tallahassee, FL 32302-1757
Telephone: Toll free (888) 945-7401 **Fax: 850-222-380**
Email: FMPTF@flcities.com

Notice of Election to participate in the DEFERRED RETIREMENT OPTION PROGRAM "DROP"

This application must be signed in all areas where Signature is requested or it will be returned to you

Employer Name: _____

Name: _____ *Social Security #: _____

Address: _____ City: _____ State ____ Zip _____

Email address where your quarterly statement should be sent: _____

Resignation from Employment and Participation in the DROP:
I elect to participate in the DROP in accordance with the Plan Document adopted by the Retirement Plan and Trust for my Employer and resign my employment on the day I terminate from the DROP. I understand that the earliest date my participation in the DROP can begin is the first date I reach my normal retirement date as determined by the Plan and my DROP participation cannot exceed a maximum of _____ months as set by my Plan, although I may elect to participate in the DROP for less than that time period. I understand that my participation in the DROP does not guarantee my employment for the DROP period.

DROP begin date: _____ DROP Termination and Resignation Date: _____

DROP Account Beneficiary Form

In the event of my death prior to the conclusion of my participation in the DROP, I hereby designate the following Beneficiary(ies) to receive my DROP account balance

Primary Beneficiary(ies): _____ Social Security #: _____

Relationship: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Benefit percentage: _____
If more than one primary beneficiary is designated, provide all information for each beneficiary and percentage of benefit, which must equal 100%.

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Contingent Beneficiary(ies): _____ Social Security #: _____

Relationship: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Benefit percentage: _____

If more than one contingent beneficiary is designated, provide all information for each beneficiary and percentage of benefit, which must equal 100%. The designation of a beneficiary is applicable under this plan benefit only if the primary beneficiary designated above is not living at the time of the participant's death.

If no primary or contingent beneficiary is living at the time of death of the participant, the participant's DROP benefits will be distributed to the participants' estate.

The right to revoke this designation of beneficiary by the participant is reserved by signing and filing with the Employer a new beneficiary designation form. The consent of a participant's beneficiary to any change of beneficiary shall not be required.

Participant Signature ***(sign in the presence of a Notary)*** _____

Notary: State of Florida, County of _____. Sworn to and subscribed before me this _____ day of _____ by _____ Personally known ____ or produced _____identification.

_____
Signature of Notary Public – State of Florida

Print, Type or Stamp Commissioned Name of Notary Public

Employer Signature _____ **Date** _____

Print Employer Name and Title _____

*Social Security numbers are requested and maintained on behalf of all plan participants, beneficiaries and retirees for data collection, reconciliation, tracking, benefit processing, tax reporting, and identity verification purposes. Social Security numbers are also used as a unique numeric identifier and may be used for death record searches for retirees.