



REQUEST FOR RETURN OF EMPLOYEE CONTRIBUTIONS ONLY

Plan Name: City of Satellite Beach Fire and Police Pension Plan

Name: _____	*Social Security #: _____ / _____ / _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
Phone Number: (____) _____	E-mail: _____	
Date of Birth: ____ / ____ / ____	Date of Hire: ____ / ____ / ____	Date of Entry: ____ / ____ / ____

RETURN OF EMPLOYEE CONTRIBUTIONS BEFORE EARLY OR NORMAL RETIREMENT

By signing below, I elect to receive only my accumulated employee contributions plus interest, if any as outlined in the plan document. I understand receipt of these funds prior to early or normal retirement will cause immediate suspension of further contribution and participation as well as any entitlement to benefits whatsoever under my employer's retirement plan. My request will be processed within 90 days.

Signature

Date

SPECIAL TAX NOTICE REGARDING PLAN DISTRIBUTIONS

Participants should review the Special Tax Notice regarding plan distributions (attached) before deciding how to receive benefits from the employer's retirement plan. In particular, this notice explains that 20% of your plan distribution is required to be withheld for federal income tax purposes unless you elect a direct roll-over of your Plan benefits to another employer plan or an individual retirement arrangement (IRA). *(If this form is not attached, please request from the administrator.)*
I have reviewed and understood the provisions of the Special Tax Notice Regarding Plan Distributions.

Signature of Plan Member Required

Date

Participant's Certification – Waiver of 30 day waiting period

I wish to have my distribution from the plan made as soon as possible. Therefore, I, hereby waive the 30-day time period otherwise required between the date the "Special Tax Notice" was provided to me and the date that my election regarding my disbursement is implemented.

In connection with this waiver, I hereby confirm the following:

I acknowledge receipt of a written "Special Tax Notice", informing me of some of the tax implications associated with the distribution options available to me; that I understand that I am entitled to a reasonable period of not less than 30 days from the date the notice was provided to me in which to decide whether or not to elect a direct rollover or lump sum until my distribution is actually implemented.

Participant Signature

Date

****Lump Sum Payment Options:**

A return of contributions from the Plan that is eligible for "rollover" (pre-tax contributions) can be taken in two ways. You can have all or any portion of your payment either (A) PAID IN A "DIRECT ROLLOVER" **OR** (B) PAID TO YOU. A rollover is a payment of your Plan benefits to your individual retirement arrangement (IRA) or to another employer plan. Your choice will affect the taxes you owe. Consult a tax professional if you have questions. Please initial your choice on the line provided.

CHOOSE 1 option below – either Direct Rollover or Paid to You:

DIRECT ROLLOVER

A. _____ I choose a direct rollover. I am rolling over to (choose one): Traditional IRA
Deferred Comp 457(b)
Other: (specify) _____

CHOOSE ONE BELOW:

Please initial your choice on the line provided.

_____ I choose to have a **check** paid to my financial institution and mailed to my financial institution.
Make check payable to: _____ and mail to: _____

_____ I choose to have my rollover payment **wired directly** to my financial institution.
I have enclosed a **check payable to the Florida League of Cities for \$15** to cover the wire fee. **I understand the \$15 payment must accompany this application.**
We are unable to withhold the \$15 fee from your distribution amount.

Wire Instructions:

Bank Name: _____

ABA# _____

Bank Account # _____

PAID TO YOU

B. _____ I acknowledge that 20% will be withheld from my plan distribution and that additional withholding may be required for early distribution. **"After Tax" employee contributions are non-taxable when paid to you and they are ineligible for rollover. In order to receive my payment, I have enclosed a completed Direct Deposit Form and voided check with this form.**

Participant Signature

Date

To Be Completed By the Employer

Salary & EE Contribution History broken down by fiscal year must be attached.

Date of Hire: ___/___/___ Date of Termination ___/___/___

I have reviewed this request for a return of employee contribution only and provided the salary history and employee contribution information in accordance with our payroll records.

Employer Signature, Title

Date

Please submit ALL of the following:

- (1) Request for Return of Contributions Form
- (2) Copy of your Social Security Card
- (3) If payable directly to you - Direct Deposit Agreement, including a voided check
- (4) If you choose a rollover to be wired, include a check for \$15 **and** wiring instructions.

Return to: Florida Municipal Pension Trust Fund

ATTN: Retirement Services
Post Office Box 1757
Tallahassee, FL 32302-0757

Contact number: (850) 222-9684
Fax: (850) 222-3806
Email: FMPTF@flcities.com

*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.

**We are unable to provide tax advice. Please contact a Tax Advisor in order to make your decision on how to receive your contributions. A Special Tax Notice is provided to you along with this request form to provide general guidance.