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
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ENROLLMENT AND BENEFICIARY DESIGNATION FORM

____ RETIREMENT PLAN

(enter Employer name above)

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

I, ______________________________, do hereby elect to participate in the ______________________________ Retirement Plan (the Plan). I understand that my election to participate in the Plan is irrevocable.
In the event of my death, I hereby designate the following Beneficiary(s) to receive my death benefit from the Plan.

Name of Participant: ________________________ ***Social Security #:** ____________ **Gender:** Male___Female___

Check one: Active employee _____ Retiree_____ Deferred-Vested_____

Date of Birth: ____________ **Date of Employment:** ____________ **Division (If applicable):** _________

Employee Type: ☐ General Employee ☐ Management Employee ☐ Police Officer ☐ Full-time Firefighter ☐ Volunteer Firefighter

Address: ____________________________________ **Home Phone:** _______________

Email address: _________________________ **Cell Phone:** _______________

Beneficiaries under legal age will be granted their appropriate distribution in accordance with this form unless a specific Custodial Trust was established prior to the death of the participant, or an estate settlement changes the designation. It is the responsibility of the beneficiary to notify the Trustee (Participant's Employer) of any existing custodial or other arrangement.

Primary Beneficiary: ______________________ **Relationship:** _______________ **Gender:** Male___Female___

Date of Birth: ______________________ ***Social Security #:** __________________________

Address: ____________________________________ **Phone:** _______________ Cell__Home__Work__

Name: ______________________ **Relationship:** ________________ **Gender:** Male___Female___

Check one: Additional Primary___ Contingent___ **Benefit %** _____ **Date of Birth**: _________ ***Social Security #:** ___________

% amounts must TOTAL 100%

Address: ____________________________________ **Phone:** _______________ Cell__Home__Work__

Name: ______________________ **Relationship:** ________________ **Gender:** Male___Female___

Check one: Additional Primary___ Contingent___ **Benefit %** _____ **Date of Birth**: _________ ***Social Security #:** ___________

% amounts must TOTAL 100%

Address: ____________________________________ **Phone:** _______________ Cell__Home__Work__

Name: ______________________ **Relationship:** ________________ **Gender:** Male___Female___

Check one: Additional Primary___ Contingent___ **Benefit %** _____ **Date of Birth**: _________ ***Social Security #:** ___________

% amounts must TOTAL 100%

Address: ____________________________________ **Phone:** _______________ Cell__Home__Work__

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

________________________	____________	________________________	____________
Participant's Signature	Date	Signature of Plan Official or Notary	Date

For additional beneficiaries, add to the back of this form.

*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.

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