



FLORIDA MUNICIPAL PENSION TRUST FUND PROTECTING THE RETIREMENT OF THOSE SERVING THE PUBLIC

APPLICATION FOR DEATH BENEFIT

Plan Name: _____

Beneficiary name: _____ *Social Security#: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email address: _____

Date of Birth: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____ Work ___ Home ___ Cell ___

Plan Member's Name: _____

Plan Member's *Social Security #: _____

Plan Member's Date of Death: _____

**Proposed Benefit Date: _____

Beneficiary Signature

Date

Signature of Plan Official or Notary

Date

*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.
**All benefit payments are made on the 1st day of the month unless it occurs on a weekend or holiday, and it will then be posted the next business day.

Acknowledgement of Over/Under Payment Policy

It is required that you understand and affix your signature to the following statement:

“Any overpayments or underpayments from the Fund to a retired Member or Beneficiary caused by errors of computation shall be adjusted with interest at the rate per annum approved by the Board. Overpayments shall be charged against retirement payments next succeeding the correction. Underpayment shall be made up from the Trust Fund.”

I have read and understand the terms and conditions of the above statement.

Beneficiary Signature Date

To be completed by Employer:

*If this beneficiary payment is a continuation of a retirement benefit the member was already receiving, Employer signature is **not** required.*

Please provide a complete listing of all salary data and employee contributions based on the definition of salary in the ordinance, for the past 10 years.

Date of Hire: _____

I have reviewed this request for calculation of retirement benefits and provided the salary history information in accordance with our payroll records.

Employer Signature Title Date

PLEASE NOTE: We can't provide tax advice; please contact a Tax Advisor when completing your forms and making decisions on your retirement benefit and Federal Tax Withholding.

Check that you have included ALL of the following documents:

1. ___ Application for Death Benefit
2. ___ Copy of Member's Death Certificate
3. ___ Direct Deposit Agreement, including a voided check
4. ___ Copy of Social Security card
5. ___ Copy of birth certificate
6. ___ Form W-4P

Return to:
Florida Municipal Pension Trust Fund
ATTN: Retirement Services
P.O. Box 1757
Tallahassee, FL 32302-1757
Fax: (850) 222-3806, *Retirement Services*
Phone: (850)222-9684
Email: FMPTF@flcities.com