

APPLICATION FOR RETIREMENT BENEFITS

Plan Name: _____

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

Joint & Survivor Information:

Joint Annuitant Name: _____		*Social Security #: ____ / ____ / ____	
Date of Birth: ____ / ____ / ____	Relationship: _____		
Address: _____			
City: _____	State: _____	Zip Code: _____	

Please check the type of Benefit to Calculate:

- | | |
|---|---|
| <input type="checkbox"/> Normal Retirement | <input type="checkbox"/> Early Retirement |
| <input type="checkbox"/> Disability Benefit | <input type="checkbox"/> Death Benefit |

Proposed Benefit Date: ____ / ____ / ____

(Date Signed)

(Signature of Participant)

(Date Witnessed)

(Signature of Witness:
Plan Official or Notary Public)

*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.

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.

Signature of Plan Participant

Date

To Be Completed By The City Finance Department

October 1st - ___/___/___

Current Plan Year Employee Contribution: \$

Current Plan Year Salary: \$

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

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 submit the following:

- (1) Application for Retirement Benefits
- (2) Direct Deposit Agreement, *including a voided check or deposit ticket*
- (3) Copy of social security cards for you & your beneficiary
- (4) Copy of birth certificates for you & your beneficiary
- (5) W-4P

Return to:

Florida Municipal Pension Trust Fund
ATTN: Retirement Services
Post Office Box 1757
Tallahassee, Florida 32302-1757
Fax: (850) 222-3806
Phone: (850) 222-9684
Email: FMPTF@flcities.com