



FLORIDA MUNICIPAL PENSION TRUST FUND

PROTECTING THE RETIREMENT OF THOSE SERVING THE PUBLIC

REQUEST FOR CONVERSION FROM DROP TO NORMAL RETIREMENT

Plan Name: _____

Name: _____ *Social Security #: _____

Address: _____ City: _____ State ____ Zip _____

Last Day of Employment: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

PARTICIPANT CERTIFICATION OF DROP WITHDRAWAL

By signing below, I certify that my separation from service with my Employer listed above will occur on the withdrawal date set forth in this document. I understand that by signing this document I am electing to receive the balance in my DROP account and that this action will end my participation in the DROP. I also understand that the plan provisions will continue to govern my retirement benefit that I elected prior to entering the DROP.

Participant 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 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 rollover of your plan benefits to another qualified plan.

I have reviewed and understood the provisions of the Special Tax Notice regarding plan distributions.

Participant Signature

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.

TO BE COMPLETED BY EMPLOYER

Last day of employment: _____

I have reviewed this request for a DROP withdrawal and certify the above is correct.

Employer Signature, Title

Date

Please submit ALL of the following:

1. Request for Conversion from DROP to Normal Retirement form
2. Copy of your Social Security Card
3. If payable directly to you – Direct Deposit Agreement, including a voided check

Return to: FMPTF

P.O. Box 1757
Tallahassee, FL 32302
Fax: (850) 222-3806
Email: FMPTF@flcities.com

Contact Number: (850) 222-9684