FLORIDA MUNICIPAL PENSION TRUST FUND

Please contact the Plan Administrator if you have any questions or need more information about the Plan or the retirement process:
Florida Municipal Pension Trust Fund
ATTN: Retirement Services
Post Office Box 1757 **Telephone: 850-222-9684 Fax: 850-222-3806**
Tallahassee, Florida 32302-1757 **Email: FMPTF@flcities.com**

ENROLLMENT AND BENEFICIARY DESIGNATION FORM

_____ RETIREMENT PLAN

(enter Plan/Employer name above)

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: _____ **Phone:** Cell/Home/Work _____

Email address: _____ **Phone:** Cell/Home/Work _____

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: _____

Circle one: Additional Primary **OR** Contingent **Name:** _____ **Relationship:** _____

Benefit Percentage _____ **Date of Birth**: _____ ***Social Security #:** _____

Address: _____

Circle one: Additional Primary **OR** Contingent **Name:** _____ **Relationship:** _____

Benefit Percentage _____ **Date of Birth**: _____ ***Social Security #:** _____

Address: _____

Circle one: Additional Primary **OR** Contingent **Name:** _____ **Relationship:** _____

Benefit Percentage _____ **Date of Birth**: _____ ***Social Security #:** _____

Address: _____

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.

_____	_____	_____	_____
(Date Signed)	(Signature of Participant)	(Date Witnessed)	(Signature of Witness: Plan Official or Notary Public)

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.