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
Tallahassee, Florida 32302-1757
Telephone: 850-222-9684 Fax: 850-222-3806
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: ______________________________ **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 #:** ____________

Address: ______________________________ **Phone:** ______________ Cell ☐ Home ☐ Work ☐

Name: ______________________ **Relationship:** ______________ **Gender:** Male ☐ Female ☐

Check one: Additional Primary ☐ Contingent ☐ **Benefit %** _____ **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 #:** ____________

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.

Revised July 2022