



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 prior to termination of employment, I hereby designate the following Beneficiary(s) to receive my death benefit from the Plan.

Name of Participant: \_\_\_\_\_ \*Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Employment: \_\_\_\_\_ Division (If applicable): \_\_\_\_\_

Employee Type:  General Employee  Management Employee  Police Officer  
 Full-time Firefighter  Volunteer Firefighter

Address: \_\_\_\_\_

*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: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Contingent Beneficiary (ies) \_\_\_\_\_ Relationship: \_\_\_\_\_

Benefit Percentage \_\_\_\_\_ Date of Birth: \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Contingent Beneficiary (ies) \_\_\_\_\_ Relationship: \_\_\_\_\_

Benefit Percentage \_\_\_\_\_ Date of Birth: \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Contingent Beneficiary (ies) \_\_\_\_\_ 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)

\*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.