FMPTF
FLORIDA MUNICIPAL PENSION TRUST FUND

Florida Municipal Pension Trust Fund
Mailing address:
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ENROLLMENT AND BENEFICIARY DESIGNATION FORM

_____RETIREMENT PLAN

(enter Employer name above)

This form must be signed in all areas where Signature is requested or it will be returned to you

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: _____City:_____State:_____ Zip:_____

Email address: _____ **Phone - Cell:** _____ Home: _____

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:_____ **Benefit %** _____**Relationship:** _____ **Gender:** Male___Female___
% amounts must TOTAL 100%
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 #:** _____
% amounts must TOTAL 100%
Address: _____ **Phone:** _____ Cell__Home__Work__

Name: _____ **Relationship:** _____ **Gender:** Male___Female___

Check one: Additional Primary___ Contingent___ **Benefit %** _____ **Date of Birth**: _____ ***Social Security #:** _____
% amounts must TOTAL 100%
Address: _____ **Phone:** _____ Cell__Home__Work__

Name: _____ **Relationship:** _____ **Gender:** Male___Female___

Check one: Additional Primary___ Contingent___ **Benefit %** _____ **Date of Birth**: _____ ***Social Security #:** _____
% amounts must TOTAL 100%
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 Employer 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.