**EUSTIS FIREFIGHTERS' PENSION PLAN**
**APPLICATION FOR DROP PLAN PENSION BENEFIT**

**PLEASE PRINT OR TYPE:**

1. a. Name of Employee:_____
(last) (first) (middle)

b. Social Security Number:_____

c. Date of Birth:_____ Date Employed:_____

d. Last Department You Worked For:_____

e. Home Telephone Number:(_____)_____

f. Home Address:_____
(Address and street)

_____
(city,state,zip code)

g. Permanent Address To Which Correspondence Should Be Sent (if different):____
_____

2. a. Are you currently married: Yes_____ No_____
(If yes, complete the following for your spouse. If no, complete for your beneficiary)

b. Name of Spouse/Beneficiary:_____
(last) (first) (middle)

c. Social Security Number:_____

d. Date of Birth:_____ Date of Marriage:_____

3. Contingent Beneficiary:

a. Name & Relationship:_____

b. Social Security Number:_____

c. Address:_____

_____

4. Type of Retirement For Which You Are Applying (check one):

_____ Normal Retirement

_____ Early Retirement

5. I Understand that Prior to entering DROP, I Must Make an Election to have my DROP Account credited with either:

a. Interest at the rate applicable to the Florida Retirement System deferred retirement option plan for the calendar quarter immediately preceding the system's deferred retirement option plan calculation.

b. Net rate of investment return for the purpose of this subsection is the total return of the assets in which the member's deferred retirement option plan account is invested by the board net of brokerage commissions, transaction costs and management fees.

6. I Plan to Enter the DROP Plan on:_____

7. I Plan to Separate From Employment on:_____

(NOTE: Within ninety (90) days after the end of any calendar quarter following the termination of a Participant's employment, the balance in the Participant's DROP account shall be payable at the Participant's option:
(A) - a single lump payment or
(B) - a direct rollover to an individual retirement account (IRA) or other eligible plan.

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits. I have reviewed the Designation of Beneficiary Form filed with the Board of Trustees and I hereby certify its accuracy. If I desire to change my designated beneficiary (ies), I will file a new Designation of Beneficiary Form with this application. This application revokes any prior applications.

_____ _____

(Witness' Signature) (Employee's Signature)

Date:_____