FT. PIERCE POLICE OFFICERS' RETIREMENT TRUST FUND
APPLICATION FOR PENSION BENEFITS

PLEASE PRINT OR TYPE:

1. a. Name of Employee: _____

b. Social Security Number: _____
* In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund.

c. Date of Birth: _____ (Attach birth certificate or other proof)

d. Home Telephone Number: (___) _____

e. Home Address: _____

_____

f. Permanent address to which check and correspondence should be sent:
(It is important to keep your address and phone number updated - please notify us of any changes)

_____

_____

2. a. Are you currently married? Yes_____ No_____

If yes, please complete the following:

b. Name of Spouse: _____

c. Spouse's Social Security Number: _____
* In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund.

d. Spouse's Date of Birth: _____ (Attach birth certificate or other proof)

e. Date of Marriage: _____

3. Names and Dates of Birth of Child(ren):

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

(Attach additional page, if needed)

4. Names of Your Living Parents:

a. Mother: _____

b. Father: _____

5. a. Date of hire by Fort Pierce as Police Officer: _____

b. Current Position in the Police Department: _____

6. I plan to retire on: _____

7. Type of retirement for which you are applying:

_____ Normal Retirement

_____ Deferred Retirement Option Plan. Please be advised that the guarantee of ten (10) years retirement annuity payments commences upon the retiree's entrance into DROP.

_____ Early Retirement

_____ Line-of-Duty Disability

_____ Non-Line-of-Duty Disability

8. If you are applying for a disability retirement, please complete the following:

a. Date disability commenced:_____

b. Nature and cause of disability: _____

_____

c. Did your disability result from any of the following:

		Yes	No
(1)	Use of drugs, intoxicants or narcotics?	_____	_____
(2)	Due to a fight, riot, civil insurrection or crime?	_____	_____
(3)	From an injury or disease sustained while you were serving in any armed forces?	_____	_____
(4)	After your employment with the City terminated?	_____	_____
(5)	While working for anyone other than the City and arising out of such employment?	_____	_____

d. A copy of my doctor's medical opinion is attached: _____ _____

NOTE: If you are applying for a disability benefit, records must be filed to show that the disability is total and permanent. If application is made for a line-of-duty disability, copies of workers' compensation records must also be filed to show that the disability occurred in the line-of-duty. Also, the Board of Trustees may require you to be examined by a doctor selected by the Board.

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.

FOR DISABILITY APPLICATIONS ONLY:

I hereby authorize the release of any and all medical records including but not limited to the complete history records in possession of all doctors listed below concerning my illness and/or treatment. A copy of this document will be treated in the same manner and have the same effect as an original.

I hereby waive my right of confidentiality of my medical records and other medical evidence in order that my application for disability benefits may be properly processed. I understand that in so doing, such records will be discussed during one or more public meetings and will become public record. I understand that the Board(s) will rely upon this waiver and that I will not be able to withdraw same at a later date.

I agree to cooperate fully with the Board of Trustees of the Ft. Pierce Police Officers' Retirement Trust Fund in making available to the Board, or authorized agents of the Board, information which reasonably relates to the initial payment of or continuing eligibility for payment of benefits from the Fund.

I hereby agree to indemnify and hold harmless the City of Ft. Pierce and the Pension Fund and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the City of Ft. Pierce's release of the results of the undersigned's annual physical to the Pension Plan and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liabilities, damages, orders, judgments, or decrees in connection therewith.

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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.

_____ _____
PARTICIPANT'S SIGNATURE DATE

STATE OF FLORIDA
COUNTY OF _____

SWORN TO (or affirmed) and subscribed before me, this _____ day of _____, 20__ by _____, who is

_____ Personally known
_____ **OR** Who Produced Identification

Type of Identification Produced: _____

_____

_____
Notary Signature
Print, type or stamp name of Notary below in addition to seal:

_____

NOTARY SEAL]

BSJ/pah
March 17, 2014
H:\Ft Pierce Pol 1155\FORMS\(2014) PENSION APPLICATION.wpd