

<p><b>TOWN OF LANTANA POLICE RELIEF AND PENSION FUND</b></p> <p><b>DESIGNATION OF BENEFICIARY</b></p>
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**PLEASE PRINT OR TYPE**

**Participant's Info**

Participant's Name: \_\_\_\_\_

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.

Date of Birth: \_\_\_\_\_

**1. Primary Beneficiary**

I hereby designate the following person as my beneficiary entitled to receive any benefit due in the event of my death:

a. Name Beneficiary: \_\_\_\_\_

b. Relationship to Participant: \_\_\_\_\_

c. Beneficiary'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. Date of Birth of Beneficiary: \_\_\_\_\_

e. Sex of Beneficiary:        Male \_\_\_\_\_ Female \_\_\_\_\_

f. Home Address of Beneficiary: \_\_\_\_\_

\_\_\_\_\_

g. Telephone Number of Beneficiary: \_\_\_\_\_

## 2. Contingent Beneficiary

If the above-named primary beneficiary dies before me, or is not available to receive any benefit due, I designate the following person as the contingent beneficiary entitled to receive any benefit due in the event of my death:

- a. Name of Contingent Beneficiary: \_\_\_\_\_
- b. Relationship to Participant: \_\_\_\_\_
- c. Beneficiary'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. Date of Birth of Beneficiary: \_\_\_\_\_
- e. Sex of Beneficiary:            Male \_\_\_\_\_ Female \_\_\_\_\_
- f. Home Address of Beneficiary: \_\_\_\_\_  
\_\_\_\_\_
- g. Telephone Number of Beneficiary: \_\_\_\_\_  

Include Area Code

The above designation of beneficiary revokes any and all prior designations of beneficiaries. I understand that the beneficiary I select may affect the amount of benefits to be paid to me.

**BE SURE TO KEEP YOUR BENEFICIARY AND CONTACT INFORMATION UPDATED WITH THE FUND**

**THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO  
WILL THEN BE ABLE TO NOTARIZE THE FORM**

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

**STATE OF** \_\_\_\_\_

**COUNTY OF** \_\_\_\_\_

SWORN TO (or AFFIRMED) AND SUBSCRIBED before me this \_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_.

\_\_\_\_ Personally known

\_\_\_\_ OR Produced identification

Type of identification produced: \_\_\_\_\_

\_\_\_\_\_  
Signature, Notary Public

\_\_\_\_\_  
Printed Name of Notary\*

*\*In accordance with the provisions of §117.04(4)(i),  
below the signature, the name of notary must be  
printed, typed or stamped. The Notary seal must be  
affixed to the side of the signature or below the  
printed name.*