CITY OF MARCO ISLAND FIREFIGHTERS' PENSION FUND
Application for Benefits Payable as a Result of Retirement

Participant:

Name:_____ Social Security No.:XXX-XX-_____

Address:_____ Phone Number:_____

Birth Date: __/__/____ Employment Date: __/__/____ Termination Date: __/___/____

Beneficiary Information:

Name: _____ Social Security No.: XXX-XX-_____

Address: _____ Phone Number: _____

Relationship: _____ Date of Birth: ___/___/____

If additional beneficiaries are designated please attach a separate page.

I hereby apply for the following benefit from the Retirement System:

__ Normal Retirement __ Early Retirement __ Service-connected Disability __ Nonservice-connected Disability

I elect the following benefit payable at the beginning of each month commencing on ___/____/____. I understand that the amount of my monthly benefit depends on the optional form of annuity that I choose, and I have indicated below (by initialing) which optional benefit form I elect to receive.

_____ 1. **STANDARD BENEFIT:** The standard pension benefit shall be a monthly benefit payable for at least 120 months and to you as long as you live thereafter. If you should die before 120 monthly payments have been made, the same amount will continue to be paid to your beneficiary or estate until a total of 120 monthly payments have been made in all.

_____ 2. **100% JOINT AND LAST SURVIVOR ANNUITY**: This option provides monthly payments to you as long as you live. Your designated beneficiary, if living at the time of your death, will then receive monthly payments equal to your monthly payment as long as he/she lives. The pension benefit amount shall be adjusted so as to be actuarially equivalent to the standard benefit.

_____ 3. **75% JOINT AND LAST SURIVOR ANNUITY**: This option provides monthly payments to you as long as you live. Your designated beneficiary, if living at the time of your death, will then receive monthly payments equal to 75% of your monthly payment as long as he/she lives. The pension benefit amount shall be adjusted so as to be actuarially equivalent to the standard benefit.

_____ 4. **66 2/3% JOINT AND LAST SURIVOR ANNUITY**: This option provides monthly payments to you as long as you live. Your designated beneficiary, if living at the time of your death, will then receive monthly payments equal to 66 2/3% of your monthly payment as long as he/she lives. The pension benefit amount shall be adjusted so as to be actuarially equivalent to the standard benefit.

_____ 5. **50% JOINT AND LAST SURVIVOR ANNUITY**: This option provides monthly payments to you as long as you live. Your designated beneficiary, if living at the time of your death, will then receive monthly payments equal to 50% of your monthly payment as long as he/she lives. The pension benefit amount shall be adjusted so as to be actuarially equivalent to the standard benefit.

_____ 6. **LIFE ANNUITY**: This option provides payment to you as long as you live. If you should die before you have received an amount equal to your own contributions to the Pension Fund, payments will continue to your beneficiary or estate until your own contributions with interest have been used up. The pension benefit amount shall be adjusted so as to be actuarially equivalent to the standard benefit.

_____ 7. **OTHER BENEFIT:** Another benefit that is actuarially equivalent to the standard benefit as described in an attached document, which must be formally approved by the Board of Trustees during a regularly scheduled meeting.

I understand that my designation of beneficiary above revokes all prior such designations and that Beneficiary benefit amounts will be based on the beneficiary named above and shall be payable only to such designated beneficiary. I further understand that should I wish to change my beneficiary, new payment amounts will have to be calculated.

In the event that I am eligible for a disability benefit I understand that the plan has a right of subrogation against any 3rd-party to the extent that the plan is obligated to make any disability benefit payments as a result of injuries caused such 3rd-party. Additionally, I acknowledge that I must notify the board of any claim or legal action asserted against any 3rd-party or insurance carrier for such injuries and that I may not settle any claim without prior consent of the board. I also acknowledge that in the event that I fail to comply with the terms stated herein my disability pension benefits may be denied or discontinued by the board.

IN LIEU of the above I elect to withdraw in one payment the total amount standing to my credit as accumulated contributions in the Retirement System. I understand that this action will cause a taxable event and that appropriate tax reductions and penalties will be withheld from this total amount.

_____

Signature

I accept the terms above, including my choice of benefit form, and confirm the information shown above to be correct.

PARTICIPANT'S SIGNATURE:_____ **DATE:**_____

Received by:

Authorized BOARD OF TRUSTEE Designee: _____ **DATE:**_____