CITY OF MARCO ISLAND POLICE OFFICERS' PENSION FUND
Enrollment in Fund

Participant:

Name:_____ Social Security No.:___-____-____

Address:_____ Phone Number:_____

Birth Date: __/__/____ Employment Date: __/__/____

Beneficiary Information:

Designated beneficiary:

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

Address: _____ Phone Number: _____

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

Contingent beneficiary:

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

Address: _____ Phone Number: _____

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

A Participant may from time to time change a designated Beneficiary by written notice to the Board upon forms provided by the Board. Upon such change, the rights of all previously designated beneficiaries to receive any benefits under the Plan shall cease. A change of beneficiary shall not require consent of the beneficiary.

A certified statement as to prior medical history, and a waiver to release and access medical records must be attached. Verification of the City of Marco Island's pre-employment medical examination shall suffice as a statement of prior medical history.

It is understood that Participants in the Plan shall be required to make contributions to the Fund in the amount of _____ (___%) of salary. By signature below the participant authorizes deduction of such percentage from salary each pay period.

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

RECEIVED BY:

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