ACKNOWLEDGMENTS

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.

I hereby waive my right of confidentiality of my medical records an 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 Palm Beach Gardens Police Pension Fund in making available to the Board, or authorized agents of the Board, information which reasonably relates to the initial payment of benefits from the Fund.

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

Dated this ____ day of _____, 20____.

_____ _____

Witness Printed Name of Participant

_____ _____

Witness Signature of Participant

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) before me and subscribed by this _____ day of _____, 20____ by _____.

___ Personally known **-OR-**

___ Produced identification

Type of identification produced: _____

_____

Notary Public, State of Florida At Large

[Notary Seal]