

**PLEASE PRINT OR TYPE:**

- 1.a. Name of Employee: \_\_\_\_\_  
(last) (first) (middle)
- b. Social Security Number\*: \_\_\_\_\_
- c. Date of Birth: \_\_\_\_\_ (attach proof) Date Employed: \_\_\_\_\_
- b. Last Department You Worked For: \_\_\_\_\_
- e. Home Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_
- f. Home Address: \_\_\_\_\_  
(address and street)  
\_\_\_\_\_  
(city, state, zip code)
- g. Permanent Address To Which Correspondence Should Be Sent (if different): \_\_\_\_\_  
\_\_\_\_\_
- h. Email address: \_\_\_\_\_
- 2.a. Please complete the following for the person you wish to be your joint pensioner for a survivorship option under the Plan.
- b. Name of Joint Pensioner: \_\_\_\_\_  
(last) (first) (middle)
- c. Social Security Number\*: \_\_\_\_\_
- d. Date of Birth: \_\_\_\_\_ (attach proof)
- e. If the joint pensioner is your spouse, Date of Marriage: \_\_\_\_\_
3. Beneficiary(ies):
- a. Name & Relationship: \_\_\_\_\_
- b. Social Security Number\*: \_\_\_\_\_
- c. Address: \_\_\_\_\_

4. Type of Retirement For Which You Are Applying (check one):

\_\_\_\_\_ Normal Retirement

\_\_\_\_\_ Non-Service Incurred Disability

\_\_\_\_\_ Early Retirement

## Deferred Vested Termination

\_\_\_\_\_ Service Incurred Disability \_\_\_\_\_ DROP

5. I plan to retire or enter the DROP on: \_\_\_\_\_  
(ie, if separating from employment on January 31, your retirement date would be February 1)

6. If you are applying for a Disability Benefit:

- 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) A fight, riot or civil insurrection?
- \_\_\_\_ (3) While you were committing a crime?
- \_\_\_\_ (4) From an injury or disease sustained while you were serving in the  
armed forces?
- \_\_\_\_ (5) After your employment with the City terminated?
- \_\_\_\_ (6) While working for someone other than the City and arising out  
of such employment?

**NOTE:** Records must be filed, including copies of a doctor's opinion, medical records and other documentation to show that the disability is total and permanent, and if application is made for a service-incurred disability, copies of workers' compensation records and other documentation must also be filed to show the disability occurred while performing service-related duties. 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. This application revokes any prior applications I may have filed.

(Witness' Signature)

(Employee's Signature)

Date: \_\_\_\_\_

\*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.