TEQUESTA PUBLIC SAFETY OFFICERS' PENSION FUND

APPLICATION FOR PENSION BENEFITS

PLEASE PRINT OR TYPE:

1. a. Name of Employee:_____

   b. Social Security Number*:_____

   c. Date of Birth:_____(Attach copy of birth certificate or other proof)

   d. Home Telephone Number:_____ (Include area code)

   Additional Phone Number:_____ (Include area code)

   e. Home Address:_____

   f. Permanent mailing address to which check and correspondence should be sent:_____

   _____

2. a. Are you currently married? Yes ____ No____

   If yes, please complete the following:

   b. Name of Spouse:_____

   c. Spouse's Social Security Number*:_____

   d. Spouse's Date of Birth:_____(Attach birth certificate or other proof)

   e. Date of Marriage:_____(Attach copy of certificate of marriage)

***In accordance with the provisions of §119.071(5)(6)(g), Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund.**

3. Names and Dates of Birth of Child(ren):

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Attach additional page, if needed)

4. Names of Your Living Parents:

   a. Mother: _____

   b. Father: _____

5. a. Date of hire by the Village as a Public Safety Officer:_____

   b. Current Position with Public Safety Department: _____

6. I plan to retire on: _____ (*Date*)

7. Type of retirement for which you are applying:

   ☐ Normal Retirement

   ☐ Deferred Retirement Option Plan

   ☐ Early Retirement

   ☐ Line-of-Duty Disability

   ☐ Non-Line-of-Duty Disability

8. If you are applying for a disability retirement, please complete the following:

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)	Due to a fight, riot, civil insurrection or crime?	☐	☐
(3)	From an injury or disease sustained while you were serving in any armed forces?	☐	☐
(4)	After your employment with the Town terminated?	☐	☐
(5)	While working for anyone other than the City and arising out of such employment?	☐	☐

d. A copy of my doctor's medical opinion is attached: ☐ ☐

9. Plan Information: Have you purchased time under the Buyback Policy?

YES ☐ NO ☐

If you answered yes, when did you purchase this time and how many years of service did you purchase? _____

NOTE: If you are applying for a disability benefit, records must be filed to show that the disability is total and permanent. If application is made for a line-of-duty disability, copies of workers' compensation records must also be filed to show that the disability occurred in the line-of-duty. Also, the Board of Trustees may require you to be examined by a doctor selected by the Board.

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 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.

_____ _____

EMPLOYEE'S SIGNATURE DATE

STATE OF FLORIDA
COUNTY OF _____

SWORN TO (or affirmed) and subscribed before me, this _____ day of _____, 2_____ by _____.
(Please print name of employee)

Please check one: Employee is: ☐Personally known to me; **OR**
☐Produced Identification

Type of Identification Produced:_____

_____
Notary Signature
Notary must *Print, type or stamp name below:*

_____
Notary Print Name

[NOTARY SEAL]