Florida Retirement System Pension Plan

Beneficiary Designation Form for the Alternate Payee of a DROP Participant

PO Box 9000, Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 **Toll Free:** 844-377-1888 **FAX:** 850-410-2010

Member Name: _____ **Member SSN:** XXX-XX- _____

Alternate Payee Name: _____ **Alternate Payee SSN:** XXX-XX- _____

Alternate Payee Mailing Address: _____ _____
Street / PO Box Apt No

_____ _____ _____
City State ZIP Code

Primary Phone: _____ **Primary Email:** _____

This form is for the alternate payee of an approved Qualified Domestic Relations Order (QDRO). As the alternate payee of an approved QDRO, I name the beneficiaries listed below to receive the benefits accrued to me in the member's Deferred Retirement Option Program (DROP) accrual account should I predecease the member before the member terminates his or her employment and takes receipt of the funds accrued in the member's DROP account. **I understand that my portion of the DROP accrual will stop at the end of the month of my death, and payment of my portion of the DROP accrual will be made to my beneficiary with interest when the member terminates employment and takes receipt of the funds in his or her DROP account.**

Please list (type or print) your beneficiaries' information below. Return the notarized form to the Division of Retirement (division) at the above address and keep a copy for your records. Call the division if this form does not meet your individual needs.

Beneficiary Designation:

1. **Primary Beneficiary(ies)** - Indicate percentages if naming more than one primary beneficiary. Percentages for primary beneficiaries must total 100 percent. If all primary beneficiaries predecease the alternate payee, the DROP accrual will be paid to the contingent beneficiary(ies).

Beneficiary	SSN (last 4)	Relationship	Date of Birth (MM/DD/YYYY)	Sex	Percentages
A._____	_____	_____	_____	_____	_____%
B._____	_____	_____	_____	_____	_____%
C._____	_____	_____	_____	_____	_____%

2. **Contingent Beneficiary(ies)** - Indicate percentages if naming more than one contingent beneficiary. Percentages for contingent beneficiaries must total 100 percent. If all primary and contingent beneficiaries predecease the alternate payee, the DROP accrual will be paid to the alternate payee's estate.

Beneficiary	SSN (last 4)	Relationship	Date of Birth (MM/DD/YYYY)	Sex	Percentages
A._____	_____	_____	_____	_____	_____%
B_____	_____	_____	_____	_____	_____%
C_____	_____	_____	_____	_____	_____%

Signature:

Alternate Payee Signature: _____ **Date**: _____/_____/_____

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Member Name: _____ **Member SSN:** XXX-XX- _____

Pursuant to the Privacy Act of 1974, 5 U.S.C. section 552a, the Division is responsible for informing you whether disclosure of your social security number is mandatory or voluntary, by what statutory or other authority your social security number is solicited, and what uses will be made of your social security number. Under section 119.071(5)(a)2., F.S., a state agency may collect your social security number if the collection is specifically authorized by law or if it is imperative for the performance of the agency's duties and responsibilities as prescribed by law.

Disclosure of your social security number on this form is: mandatory pursuant to the Welfare Reform Act, 42 U.S.C. section 666. The purpose(s) for the requested information is that social security numbers collected on the form will be used by the Department of Management Services as follows: identification of payee; enforcement of child support or alimony obligations; other deductions permitted by section 121.091, F.S., or otherwise permitted by law. Your social security number is confidential and exempt from the disclosure requirements of section 119.07(1), F.S., and section 24(a), Article I of the Florida Constitution and will not be used for any purpose other than the purpose(s) provided herein, or as otherwise authorized under section 119.071(4) and (5), F.S.

A copy of this Privacy Statement is provided to you as required by section 119.071(5)(a)3., F.S.