

**Florida Retirement System Pension Plan**  
Extension of Deferred Retirement Option Program (DROP) for Specified K-12 Personnel

PO Box ~~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-~~ \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_ Street / PO Box \_\_\_\_\_ Apt No \_\_\_\_\_

Member Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Primary Email: \_\_\_\_\_

Position Title: \_\_\_\_\_

Current FRS Employer(s): \_\_\_\_\_

Position Title \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Mailing Address \_\_\_\_\_ Present FRS Employers (s) \_\_\_\_\_

K-12 instructional personnel with a district school board, Florida School for the Deaf and Blind as defined in ~~section s.~~ 1012.01(2)(a)-(d), Florida Statutes (F.S.), or instructional personnel as defined in ~~section s.~~ 1012.01(2)(a), F.S., with a developmental research school are allowed to participate in the DROP beyond ~~96 60~~ months (up to a total of ~~120 96~~ months), as stated in ~~section s.~~ 121.091(13) F.S. ~~Effective July 1, 2018,~~ instructional personnel who are authorized to extend DROP participation beyond the ~~96 60~~-month period must have a termination date that is the last working day of the school year within the DROP extension granted by the employer.

K-12 administrative personnel as defined in ~~section s.~~ 1012.01(3), F.S., are also granted the potential to extend DROP participation beyond ~~96 60~~ months to reach the last working day of the school year ~~effective July 1, 2018,~~ as stated in ~~section s.~~ 121.091(13), F.S.

Any participant who is eligible to participate for more than ~~96 60~~ months must receive authorization from the employer for each year of participation after the initial ~~96 60~~-month period. To be considered eligible for the DROP extension, the participant individual must be employed and remain in an eligible position during the initial DROP period and period of extension. If the participant changes positions to a non-eligible position during the period of DROP extension, section 121.091(13)(c)5.d., F.S. applies. Participation in the DROP does not guarantee employment for the DROP period.

**DROP Dates (MM/DD/YYYY):**

Initial DROP Begin Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Initial DROP Termination and Resignation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I am requesting to extend my DROP participation through \_\_\_\_/\_\_\_\_/\_\_\_\_ (must be the last day of the last calendar month of the school year) ~~the last working day of the school year, with approval of my employer.~~

**Signature:**

Member Signature: (sign in the presence of a Notary) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Notary:** State of \_\_\_\_\_, County of \_\_\_\_\_. The above-named person who has sworn to and subscribed before me by means of [    ] physical appearance or [    ] online notarization on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, and is personally known \_\_\_\_\_ or has produced \_\_\_\_\_ as identification.

**Notary Seal**

\_\_\_\_\_  
**Print, Type or Stamp Commissioned Name of Notary Public**

\_\_\_\_\_  
**Signature of Notary Public**

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**Employer Certification:**

This is to certify that the \_\_\_\_\_ (employer agency name) has rescinded the resignation of the above-named member whose position meets the definition of an instructional/administrative position. The employer agency has approved a new termination date of \_\_\_/\_\_\_/\_\_\_\_\_, the last working day of the last calendar month of the school year. The employer agency stipulates that this member is eligible to participate in the DROP beyond 96 60 months and the member will continue working in a regularly established position as a(n) \_\_\_\_\_.

Superintendent or Designee Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Printed Name: \_\_\_\_\_ Position Title: \_\_\_\_\_

Employer Agency Number: \_\_\_\_\_

Agency Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

**Employer Phone:** \_\_\_\_\_

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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.