

Florida Retirement System Pension Plan
Deferred Retirement Option Program (DROP) Elected Officer Employment Termination
Notification

~~DROP Termination and Refund Payment Section~~
PO Box ~~9000~~ 3090

Tallahassee, FL 32315-~~9000~~3090

Local Phone: ~~850-907-6500~~ (850) 487-4856 **Toll Free:** ~~844-377-1888~~ (877) 738-3767 **FAX:** ~~850-410-2010~~

future.

This further acknowledges that I have read and understand the statements about the termination requirement.

Signature Member Certification:

I acknowledge that I will terminate or have terminated employment with my FRS employer on _____.
I further acknowledge that I have read and understand the above statements.

Member Signature: (sign in the presence of a notary): _____ **Date:** / /

Notary: State of _____, County of _____. The above named person 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

Employer Certification EMPLOYER CERTIFICATION: TO BE COMPLETED BY AGENCY HEAD OR DESIGNATED REPRESENTATIVE:

(TO BE COMPLETED BY AGENCY HEAD OR DESIGNATED REPRESENTATIVE FOR THE ELECTED OFFICE):

I certify that the above named member will terminate or has terminated on ____ / ____ / ____ with the Agency, which ~~who~~ I am authorized to represent.

Authorized Employer Signature: _____ **Date:** / /

Position Title: _____

Printed Print Name: _____ **Position Title:** _____

Employer Agency Name: _____

Employer Number Agency#: _____ **Employer Phone:** _____ **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.

