Florida Retirement System Pension Plan
Deferred Retirement Option Program (DROP)
Void Form

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-_____

Mailing Address: _____ _____
Street / PO Box Apt No

_____ _____ _____ _____
City State ZIP Code Country

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

Position Title: _____

Current FRS Employer(s): _____

I elected to participate in the DROP as follows:

DROP Begin Date: _____/_____/_____ **DROP Termination and Resignation Date:** _____/_____/_____

I have rescinded my resignation to continue my employment and I understand the following:

My DROP retirement and participation will be null and void and my Florida Retirement System (FRS) membership shall be reestablished back to the date I began the DROP. The beneficiary named while in the DROP will remain my beneficiary unless a new change of beneficiary form is submitted. The option selected upon entering the DROP is null and void and the DROP accrual is forfeited. I must apply to establish a future retirement date. When I retire, I will be required to terminate all FRS employment and submit the appropriate application for retirement benefits in the future.

Signature:

Member Signature: _____ **Date:** _____/_____/_____

Employer Acknowledgement:

This is to acknowledge that the _____ (employer name) has rescinded the resignation of the above-named member and the member will continue working in a regularly established position with FRS coverage. We understand the member's DROP participation will be null and void, the membership in the FRS Pension Plan will be reestablished back to the date the member joined the DROP and we will begin immediately reporting the correct retirement plan and contributions to the Division of Retirement. FRS will adjust previous retirement reports submitted under the DROP based upon the member not having joined the DROP. In addition, we understand that contributions, plus interest, may be required. Future retirement reports should reflect the retirement plan of active membership.

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

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

Employer Name: _____

Employer Number: _____ **Employer Phone:** _____

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.