~~DP-VOID~~
~~Rev. 04/03~~
~~Retired Payroll~~

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

~~Division of Retirement~~
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

_____
City State ZIP Code Country

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

Position Title: _____

Current FRS Employer(s): _____

~~**Position Title**~~ _____
~~**Home Phone**~~ _____ ~~**Work Phone**~~ _____
~~**Home Mailing Address**~~ _____ ~~**Present FRS Employer(s)**~~ _____

I elected to participate in the ~~Deferred Retirement Option Program (~~DROP~~)~~ as follows:

DROP Bb~~b~~egin Dd~~d~~ate: ____/____/____ **DROP Tt~~t~~ermination and Rr~~r~~esignation Dd~~d~~ate:** ____/____/____

I have rescinded my resignation to continue my employment and I understand the following:.

~~I understand~~ Mm~~m~~y DROP retirement and participation will be null and void and my FRS membership shall be reestablished back to the date I began the DROP. ~~I understand that I may not be eligible for DROP participation in the future. I will be required to terminate all FRS employment and submit the appropriate application for retirement benefits in the future. I understand that the option selected upon entering DROP is null and void and the DROP accrual is forfeited.~~ 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: ~~(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 who has produced _____ as identification.~~

~~**Notary Seal**~~

_____
~~**Signature of Notary Public**~~

_____

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~~**Print, Type or Stamp Commissioned Name of Notary Public**~~

Employer Acknowledgement~~Certification~~:

This is to acknowledge ~~certify~~ that the _____ (employer ~~agency~~ 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 ~~payrolls reported~~ 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 ~~payrolls~~ should reflect the retirement plan of active membership.

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

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

Employer Name: _____

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

~~**Authorized Employer Agency Personnel Signature:** _____~~

~~**Agency Number:** _____ **Agency Phone**: _____ **Date:** _____~~

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.