COOPER CITY GENERAL EMPLOYEES RETIREMENT PLAN
APPLICATION FOR PENSION OR DISABILITY BENEFIT

PLEASE PRINT OR TYPE:

1.a. Name of Employee:_____
(last) (first) (middle)

b. Social Security Number*:_____

c. Date of Birth:_____ (attach proof) Date Employed:_____

b. Last Department You Worked For:_____

e. Home Telephone Number: (_____) Cell Number: (_____)

f. Home Address:_____
(address and street)

_____
(city, state, zip code)

g. Permanent Address To Which Correspondence Should Be Sent (if different):_____

h. Email Address: _____

2.a. Please complete the following for the person you wish to be your joint pensioner for a survivorship option under the Plan.

b. Name of Joint Pensioner:_____
(last) (first) (middle)

c. Social Security Number*:_____

d. Date of Birth:_____ (attach proof)

e. If the joint pensioner is your spouse, Date of Marriage:_____

3. Beneficiary(ies):

a. Name & Relationship:_____

b. Social Security Number*:_____

c. Address:_____

_____

*In accordance with the provisions of Section 119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund.

4. Type of Retirement For Which You Are Applying (check one):

_____ Normal Retirement _____ Non-Service Incurred Disability

_____Early Retirement _____ DROP

_____ Service Incurred Disability

5. I plan to retire or enter the DROP on: _____
(ie, if separating from employment on January 31, your retirement date would be February 1)

6. If you are applying for a Disability Benefit:

a. Date disability commenced:_____

b. Nature and cause of disability:_____

c. Did your disability result from any of the following:

YES	NO	
____	____	(1) Use of drugs, intoxicants or narcotics?
____	____	(2) A fight, riot or civil insurrection?
____	____	(3) While you were committing a crime?
____	____	(4) From an injury or disease sustained while you were serving in the armed forces?
____	____	(5) After your employment with the City terminated?
____	____	(6) While working for someone other than the City and arising out of such employment?

NOTE: Records must be filed, including copies of a doctor's opinion, medical records and other documentation to show that the disability is total and permanent, and if application is made for a service-incurred disability, copies of workers' compensation records and other documentation must also be filed to show the disability occurred while performing service-related duties. Also, the Board of Trustees may require you to be examined by a doctor selected by the Board.

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits. This application revokes any prior applications I may have filed.

_____ _____

(Witness' Signature) (Employee's Signature)

Date:_____

Please return completed form to: Cooper City General Employees Retirement Plan
c/o Resource Centers, LLC
4360 Northlake Boulevard, Suite 206
Palm Beach Gardens, FL 33410