



**Pre-Separation Death Designation of Beneficiary Form for  
REFUND OF CONTRIBUTIONS**

In the event that I die prior to my separation as a firefighter with the City of Orlando or entry into DROP and the circumstances of my death do not qualify for the payment of monthly pension benefits (Non-line of duty death with less than 10 years of credited service or line of duty death with less than 10 years of credited service without surviving spouse or minor child), then I direct that a refund of my contributions be paid as follows:

I understand that I may designate one or more beneficiaries, including a trust, named sequentially or jointly and in whatever percentages I deem appropriate.

I understand that if I do not designate a beneficiary or if no beneficiary designated survives me that the refund of my contributions will be paid to my estate.

I understand that at the time of my Application for Retirement Benefits (Normal Service Retirement, DROP Retirement, or Disability Retirement), I have the right to elect in writing the form of payment of how I want my monthly pension benefits paid which may include a designation of a beneficiary or a joint pensioner different than the beneficiaries designated herein.

I understand that this designation may be revoked or changed by signing and filing with the Board of Trustees (by delivery to Employee Benefits) a new Pre-Separation Death Designation of Beneficiary Form for Refund of Contributions.

**PRIMARY BENEFICIARY(IES)**

1. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
2. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
3. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

NOTE: TOTAL OF PRIMARY BENEFICIARY(IES) MUST EQUAL 100%   %

If a beneficiary spot is not used, please draw a line through it, write 0% in the blank, and initial it.

In the event that the foregoing person(s) predeceases me, then the portion payable to that person(s) shall be payable as designated herein. If you designate more than one (1) primary beneficiary, you may designate that the surviving primary beneficiary(ies) shall receive the predeceased primary beneficiary(ies) share(s) or you may designate the contingent beneficiary(ies) to receive the predeceased primary beneficiary(ies) share(s):

**CONTINGENT BENEFICIARY(IES)**

1. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

2. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
3. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. Beneficiary Name: \_\_\_\_\_ DOB: \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Beneficiary  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

NOTE: TOTAL OF CONTINGENT BENEFICIARY(IES) MUST EQUAL 100  %

If a beneficiary spot is not used, please draw a line through it, write 0% in the blank, and initial it.

You may add additional primary beneficiaries, but the sum of the percentages for all primary beneficiaries must equal 100%. You may also add additional contingent beneficiaries, but the sum of the percentages for all contingent beneficiaries must equal 100%. Contingent beneficiaries will receive only the percentage of predeceased primary beneficiaries.

\_\_\_\_\_  
 Print Name Signature  
 \_\_\_\_\_  
Date

STATE OF FLORIDA  
 COUNTY OF ORANGE

The foregoing was acknowledged before me by means of  physical presence or  online notarization, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_, who is personally known to me or who has produced \_\_\_\_\_ as identification.

\_\_\_\_\_  
 NOTARY PUBLIC

My Commission Expires on: \_\_\_\_\_