CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND
PENSION ADMINISTRATIVE FORMS
TABLE OF CONTENTS

FORM	FORM NUMBER
Deferred Retirement Option Plan (DROP)Application/Agreement	DF-1
Drop Survivor Beneficiary Form	DF-2
DROP Pay-Out Option Selection	DF-3
Written Request for Confidentiality	PF-1
New Employees' Acknowledgment of Plan Membership	PF-2
Member's Designation of Beneficiary	PF-3
Application for Service Retirement Benefits	PF-4
Application for Disability Retirement	PF-5
Affidavit of Disability Benefit Recipient	PF-6
Authorization for Payment from Fund	PF-7
Member's Election of Benefit Option Service Retirements and Terminated Vested	PF-9
Member's Election of Benefit Option Disability Retirements Only	PF-10
Confirmation of Receipt of Retirement Benefits	PF-11
Election to Leave Member Contributions Deposited in Fund	PF-12
Return of Contributions to Vested Member and Waiver of Rights and Benefits	PF-13
Return of Contributions to Non-Vested Member and Waiver of Rights and Benefits	PF-14
Special Tax Notice Regarding Plan Payments	PF-15
Certification of Receipt	PF-16
Lump Sum Distribution Election Form	PF-17
Request for Service Credit Cost Information for Military Service	PF-18
Request for Service Credit Cost Information for Prior Police Service	PF-19
Rollover Request/Certification	PF-20
Agreement Concerning Deduction From Ret. Benefits For Qualified Health Insurance Premiums	PF-21
Authorization for Deduction From Retirement Benefits	PF-22
Change or Confirmation of Designated Joint Annuitant or Joint Pensioner	PF-25
Health Certificate	PF-28
Form Letter - Declaration of Investment Return	PL-1
Form Letter - Periodic Investment Report	PL-2
Form Letter - Distribution of Investment Policy Statement	PL-3
Form Letter - Follow-up to Non-Receipt of PF-11	PL-4
Form Letter - Request for Fiduciary Insurance Waiver of Recourse Premium Reimbursement	PL-5
Form Letter - -Second Follow-up and Hearing Notice for Non-Receipt of PF-11	PL-6

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

DEFERRED RETIREMENT OPTION PLAN (DROP)
APPLICATION / AGREEMENT

DATE: _____, ____

TO: Board of Trustees

In accordance with the provisions of the ordinance governing the operation of the City of North Port Police Officers' Pension - Local Option Trust Fund, the undersigned hereby makes voluntary application for participation in the Deferred Retirement Option Plan (DROP).

_____ _____
Name Date of Birth

In exchange for my membership in the DROP, I acknowledge and agree to the following:

- That in order to become a member of the DROP, I must have retired under normal service retirement, and elect to defer receipt of my retirement benefit, into my DROP Account. For the purposes of calculating my monthly retirement benefit, the effective date of my participation shall be concurrent with my effective retirement date of _____, furthermore, such election to become a member of the DROP shall be effective on the first day of the first calendar month which is at least fifteen (15) business days after the election is received by the Board or the Board's designee.

- I agree that my participation in the DROP will begin on my retirement date and will not extend beyond _____ ,which date is no later than 60 months from my effective retirement date. I hereby irrevocably elect to resign from employment as a Police Officer effective as of the previous date if I have not resigned prior thereto.

- That at no time during my participation in the DROP will I have access to, nor be able to borrow against my monthly "DROP" retirement benefit, nor any of the funds accumulated in my DROP Account.

- That funds accumulated in my DROP Account shall be debited or credited after each fiscal quarter and shall: (initial one)

  ___ be invested in the same manner and along with all of the assets of the system and earn a "net investment return". "Net investment returns" shall be credited or debited to the average daily balance of my DROP Account after each fiscal year quarter. "Net investment return" means the total return of the assets in which my account is invested less brokerage commissions, management fees and transaction costs. I hereby acknowledge that there may be losses accrued due to the investment experience. I understand that such losses will be charged against my DROP Account. I agree that any of the foregoing losses incurred are not the responsibility of the City of North Port Police Officers' Pension - Local Option Trust Fund. I understand that depending upon the investment experience of the system, my DROP Account can experience either gains or losses.

OR

___ earn interest at an effective rate of six and one half percent (6.5%) per annum compounded monthly on the prior month's ending balance.

- That I may change the election in the previous section only once during my DROP participation.

- That after my election to participate in the DROP I will not accrue any additional pension credited service or benefits in the City of North Port Police Officers' Pension - Local Option Trust Fund, even if I subsequently terminate my participation in the DROP, unless the current plan specifically provides to the contrary.

- That upon my termination from the DROP, I will make a written request for distribution and a written selection on a form provided by the Board regarding the distribution of the balance in my DROP Account, by selecting one of the following options:

    - a full and single lump sum distribution
    - rollover all or a portion of the account balance to another qualified retirement plan (as permitted by law), such as an IRA, with any amount not rolled over paid directly to me.

- That payments from my DROP Account may be subject to penalties, income tax withholding, or other withholding or liabilities required by law. No distribution or rollover will be made until I complete the forms required by the Board and my account will not be credited with earnings or interest or debited with losses after the end of the quarter immediately preceding my termination of DROP participation and prior to distribution or rollover.

- That, if I should die before my DROP Account balance is distributed, my DROP Account balance shall be paid in accordance with DROP Attachment A. I acknowledge that my selection on DROP Attachment A applies only to the balance of my DROP Account and at no time should it be construed to give the recipient any rights towards any payment of my monthly pension benefit.

- That the Board of Trustees in its discretion can amend the rules governing the DROP at any time and from time to time. Such amendments shall be in accordance with and consistent with the provisions covering the deferred retirement option plan set forth in the City's ordinances, amended from time to time, and shall, to the extent permitted by law, be binding upon all current DROP participants, all former DROP participants who have balances in their account and all future DROP participants.

- That I have read and understand the provisions of the City of North Port Police Officers' Pension - Local Option Trust Fund (the System), which establishes the Deferred Retirement Option Plan (DROP).

- That I understand that I am subject to the rules of DROP participation set forth in the ordinance, and the DROP policies and procedures adopted by the Board.

- That I understand that the Board may from time to time amend the policies and procedures governing my participation in the DROP.

- That I have had the opportunity to meet with the System's administrative staff and ask questions regarding the operation of the DROP and its effect on my benefits from the System, including but not limited to the effect that my DROP election will have on the calculation of my service pension, the form of benefit distributions, survivor benefits available to my eligible survivors, and ineligibility for disability and pre-retirement death benefits.

- That I have been advised by the System's administrative staff that I should consider seeking advice from a professional tax advisor, and understand that the System's administrative staff, although providing some general information, cannot and has not rendered legal or financial advice to me on the effect the DROP will or may have on the taxation of any benefit I may receive under the System or any potential benefit that may be received by my survivors as a survivor benefit.

- That in electing to participate in the DROP, I have received and considered information provided by the System's administrative staff. My decision to voluntarily elect to participate in the DROP is based on my understanding of the DROP program as provided for in the ordinance, and the DROP policies and procedures as adopted by the Board.

- That I meet the eligibility requirements of the DROP as set forth in the ordinance or will meet such requirements as of the intended effective date of my participation in the DROP.

- That I understand that upon the effective date of my participation in the DROP, I will begin to accrue DROP benefits, as provided for in the ordinance.

- That I understand that while my DROP benefits will be accounted for separately by the Fund, my DROP Account will not be physically separated from other System assets, until payment.

- That I understand that I can participate in the DROP for no more than a maximum of 60 months. After participating in the DROP for 5 years and until I terminate active service with the Police Department:

    - My DROP Account will not be credited with amounts equal to my monthly benefit, and I will not be entitled to receive, at any time, monthly benefits attributed to this period of time.

    - My DROP Account will not be credited with any earnings or interest or debited with losses.

- That I understand that following this 5 year period, I will not resume earning credited service or adjustments in my compensation for retirement pension calculation purposes, unless the current plan specifically provides to the contrary.

- That I understand that as a result of my election to participate in the DROP, the following will apply from my DROP effective date forward:

    - I will forego any otherwise applicable additional improvements in my retirement pension, including, but not limited to, improvements in the benefit formula, credit for any increase in pay or years of service with the Police Department that has not been credited by the System as of the effective date of my DROP participation.

- As of the effective date of my participation in the DROP, I will also be ineligible to receive disability and pre-retirement death benefits under the terms of the ordinance.

- As of the effective date of my participation in the DROP, I shall be eligible to serve as an elected member Trustee on the pension board but I shall not be eligible to vote for elected member Trustees.

- My employment rights will not be affected including any rights included in any collective bargaining agreement which is applicable to me and that participation in the DROP is not a guarantee of employment and DROP participants shall be subject to the same employment standards and policies that are applicable to employees who are not DROP participants.

I acknowledge receipt of this four (4) page Application/Agreement. By signing this form, I accept the responsibility to review and understand all the provisions of the Application/Agreement and the City of North Port Police Officers' Pension - Local Option Trust Fund. I also acknowledge that the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund does not act as my legal or financial advisor in this DROP Application/Agreement and that all decisions are my responsibility and that I have been advised to seek independent legal and financial advice.

_____
Signature of Applicant

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

DROP ATTACHMENT "A"

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

DROP SURVIVOR BENEFICIARY FORM

If I, _____, should die before my DROP Account balance is distributed, the following person or persons:

_____ _____%
Name

_____
Date of Birth / Relationship

_____ _____%
Name

_____
Date of Birth / Relationship

_____ _____%
Name

_____
Date of Birth / Relationship

_____ _____%
Name

_____
Date of Birth / Relationship

The pay-out of the DROP Account balance selected by the foregoing shall be in addition to any payments payable according to the retirement option selected. In the event that one of the foregoing person(s) predeceases the other beneficiaries their portion shall be divided equally among the above surviving beneficiaries.

In the event that all the foregoing person(s) predecease me, then the portion payable to that person(s) shall be payable to the following person or persons:

_____ _____%
Name

_____
Date of Birth / Relationship

_____ _____%
Name

_____
Date of Birth / Relationship

In the event that all of the foregoing persons predecease me, then the balance of my DROP Account shall be paid to my estate.

_____
Signature

_____
Date

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

DF-2
03-31-20

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

PAY-OUT OPTIONS FROM DROP

I, _____, make the following pay-out option selection from my DROP Account.

_____ A full and single lump sum distribution.

_____ Rollover all or a portion of the account balance to another qualified retirement plan (as permitted by law) such as an IRA, with any amount not rolled over paid directly to me.

The distributions from my DROP Account may be subject to penalties, income tax withholding, or other withholding or liabilities required by law.

Should I die before my DROP Account balance is distributed, my DROP Account balance shall be paid out in accordance with DROP Attachment A. The pay-out of the DROP Account balance selected by the foregoing shall be in addition to any payments payable according to the retirement option selected. I acknowledge that this contingency applies only to the balance of my DROP Account and at no time should it be construed to give the recipient any rights towards any payment of the monthly pension benefit.

_____
Signature

_____
Date

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

DEFERRED RETIREMENT OPTION PLAN (DROP) CHANGE OF ACCOUNT RETURN ELECTION

Pursuant to my original Deferred Retirement Option Plan (DROP) Application/Agreement dated _____ (copy attached) and in accordance with the provisions of the ordinance governing the operation of the City of North Port Police Officers' Pension - Location Option Trust Fund, I, _____, hereby make a voluntary amendment to my original application/agreement.

The funds accumulated in my DROP Account shall be amended to reflect: (initial one)

_____ 1. Be invested in the same manner and along with all of the assets of the system and earn a "net investment return". "Net investment returns" shall be credited or debited to the average daily balance of my DROP Account after each fiscal year quarter. "Net investment return" means the total return of the assets in which my account is invested less brokerage commissions, management fees and transaction costs. I hereby acknowledge that there may be losses accrued due to the investment experience. I understand that such losses will be charged against my DROP Account. I agree that any of the foregoing losses incurred are not the responsibility of the City of North Port Police Officers' Pension - Location Option Trust Fund. I understand that depending upon the investment experience of the System, my DROP Account can experience either gains or losses.

_____ 2. Earn interest at an effective rate of six and one half percent (6.5%) per annum compounded monthly on the prior month's ending balance.

My amended DROP benefit option will become effective on _____, which is the first day of the quarter immediately following execution of this amendment form and receipt of this form by the Board.

By signing this amendment, I acknowledge and understand that this is the only amendment allowed to my DROP application. I also acknowledge that the Board of Trustees of the City of North Port Police Officers' Pension - Location Option Trust Fund does not act as my legal or financial advisor with respect to this DROP Amended Application/Agreement and that all decisions are my responsibility and that I have been advised to seek independent legal and financial advice.

_____
Signature of Applicant

_____
Print Name

_____
Date

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

Received by the Board on _____, 20_____.

By:_____

WRITTEN REQUEST FOR CONFIDENTIALITY

TO: The Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund

In accordance with Chapter 119.071(4)(d)3., Florida Statutes, the City of North Port hereby makes this written request for confidentiality as to all personal information pertaining to all Police Officers of the City and their spouses and children, which said Chapter authorizes to be maintained as confidential.

Dated this _____ day of _____, 20____.

CITY OF NORTH PORT

By:_____
As

PF-1
02-20-15

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

NEW EMPLOYEES' ACKNOWLEDGMENT OF PLAN MEMBERSHIP

TO: BOARD OF TRUSTEES

(1) I hereby acknowledge all the terms and conditions of the City of North Port Police Officers' Pension - Local Option Trust Fund, and

(2) I have been furnished with a Summary Plan Description.

SIGNED THIS _____ Day of _____, 20___.

Date of Birth:

_____ _____
(Member Name Printed)

_____
(Signature)

_____
(Street Address)

_____
(City) (State) (Zip Code)

ACCEPTED THIS _____ DAY OF

_____, 20___.

BOARD OF TRUSTEES

By:_____

(1 copy for Member, 1 copy for Board)

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

MEMBER'S DESIGNATION OF BENEFICIARY

Type or print

PART A - MEMBER INFORMATION

_____ _____ _____
Member's Name (First, Middle, Last) Date of Birth Telephone Number

_____
Address (Street Address, City, State, Zip Code)

Are you retired? _____ Yes _____ No

PART B - PRIMARY Beneficiary or Primary Beneficiaries in Equal Shares, Survivors or Survivor*

Name	Sex	Trust, Estate or Relationship	Birth Date (Mo/Day/Yr)	Present Address
1.				
2.				
3.				

PART C - CONTINGENT Beneficiary or Contingent Beneficiaries in Equal Shares, Survivors or Survivor*

1.				
2.				
3.				

***If additional space is needed, USE ADDITIONAL FORMS. Do not attach plain paper or continue to the back of this form.**

☐ **If you are using additional forms, check this box.**

If no primary beneficiary survives the member, all benefits payable will be paid to the contingent beneficiary(ies). In the event no contingent beneficiary(ies) survive(s) the member, all proceeds will be paid to the member's estate.

_____ _____
Date Signature of Member

_____ _____
Date Witness Signature (may *not* be a named beneficiary)

(1 Copy to Member, 1 Copy to Board)

Designation of Beneficiary Instructions

Important

A member may designate any natural person or persons, trust, or estate as beneficiary. The Board of Trustees recognizes only those designations which are received in the Retirement System's office prior to the member's death. When you name a beneficiary or beneficiaries, this person or persons will receive any and all benefits payable as a result of your death. **THIS FORM DOES NOT AFFECT BENEFITS PAYABLE TO JOINT PENSIONERS DESIGNATED AS SUCH UNDER A JOINT AND SURVIVOR BENEFIT OPTION.** Any beneficiaries named will share equally in the benefits payable. This form supersedes and revokes any and all prior designations and primary/contingent beneficiary(ies).

INSTRUCTIONS

Completion of Form - This designation of beneficiary form must be typed or printed by the member. Please complete the form carefully. Forms that appear to be modified or altered in any way will not be accepted. The member's name should be signed in the same manner as it appears on the form. **This form will replace all previous beneficiary designations; therefore, it should be correctly and thoroughly completed.**

Witnesses - A witness for the member's signature is required. **The witness must be a disinterested party, not a beneficiary.**

Beneficiaries - **A member may designate any natural person or persons, trust or estate as beneficiary.** To name a primary beneficiary only, the name of the beneficiary, relationship to the member and date of birth, and address should be entered in the space below the heading, Primary Beneficiary". In such case, the area below the heading, "Contingent Beneficiary" should be left blank. If a contingent beneficiary is desired, both areas must be completed. The information relating to the primary beneficiary should be inserted in the area below the heading "Primary Beneficiary", and the information relating to the contingent beneficiary should be inserted under the heading, "Contingent Beneficiary". More than one primary beneficiary and more than one contingent beneficiary may be named. Example: If you previously named a primary and contingent beneficiary and you now wish to change only the primary beneficiary, yet wish to keep the previously named contingent beneficiary, you must still complete the contingent beneficiary section on the latest form since it revokes and supersedes all other forms previously submitted.

Trust/Estate - If you choose to name a trust/estate as a beneficiary, provide the name and address of the trust/estate. (Example: John Doe, Trust #1, Sixth National Bank, Orlando, Florida 32809) No other primary beneficiaries may be designated if you name a trust/estate as primary beneficiary, but you may name other contingent beneficiaries. No other contingent beneficiaries may be designated if you choose to name a trust/estate as contingent beneficiary.

Notice

If any designated Beneficiary shall predecease you, the rights and interests of such Beneficiary shall thereupon automatically terminate; in such event any interest held by that Beneficiary by or through you, by reason of your death and participation herein, shall cease and terminate completely.

You reserve the right to change the designated Beneficiaries at any time upon filing a new written request with the Board and which request, when received by the Board, shall revoke any prior selection or designation of Beneficiary. The consent of a Beneficiary shall not be required to effectuate any change.

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

APPLICATION FOR SERVICE RETIREMENT BENEFITS

Name of Employee: _____

Social Security Number: _____

Date of Employment: _____ Date of Birth: _____

Permanent Address: _____

_____

Daytime Phone Number: _____

Type of benefit for which you are applying:

* Normal (_____)

  DROP: Yes ___ No ___

* Early (_____)

  Deferred: ___ Immediate: ___

I plan to retire or DROP on: _____

Last date of work: _____

If Joint and Survivor option is to be calculated, name of joint annuitant:

_____

Relationship: _____

Social Security Number: _____

* Date of Birth: _____

Address: _____

* *Attach birth certificate or driver's license for proof of age*

I hereby request that the Board of Trustees calculate my retirement options based on the information provided above. I understand I will make my final retirement option selection upon receipt of the calculation of the monthly amounts for the various benefit options.

I hereby certify that the preceding statements are true and correct to the best of my knowledge. I also certify that I will adhere to the requirements of the Plan. I understand a false statement may disqualify me for benefits.

This application revokes any prior application.

Signature: _____

Date: _____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me, by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

CITY OF NORTH PORT POLICE OFFICERS' PENSION -
LOCAL OPTION TRUST FUND

APPLICATION FOR DISABILITY RETIREMENT

THE UNDERSIGNED MEMBER OF THE SYSTEM HEREBY APPLIES FOR DISABILITY RETIREMENT FROM THE CITY OF NORTH PORT POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND.

NAME: _____ TEL. NO. _____

ADDRESS: _____

_____ _____

DATE OF BIRTH: _____

DATE OF EMPLOYMENT: _____ JOB TITLE _____

DATE OF INJURY OR ONSET OF ILLNESS: _____

SPECIFY WHETHER OR NOT INCURRED IN THE PERFORMANCE OF YOUR DUTIES AS A POLICE OFFICER. ☐ In-Line ☐ Not-in-Line

DESCRIPTION OF ACCIDENT, ILLNESS OR INJURY GIVING RISE TO DISABILITY:

_____

_____

_____

CURRENT EMPLOYMENT STATUS:

☐ Active

☐ Leave of Absence

☐ Terminated

Date:_____Reason:_____

WORKERS COMPENSATION: ☐ Yes ☐ No Date: _____

***** A PHYSICIAN'S STATEMENT DESCRIBING YOUR PERMANENT DISABILITY AND SPECIFICALLY INDICATING THAT YOU ARE <u>TOTALLY AND PERMANENTLY</u> DISABLED TO THE EXTENT THAT YOU ARE UNABLE TO RENDER USEFUL AND EFFICIENT SERVICE AS A POLICE OFFICER <u>MUST BE</u> SUBMITTED WITH THIS APPLICATION.*****

<u>ELIGIBILITY FOR DISABILITY BENEFITS</u>

Subject to (4) below, you must be an active member of the plan on the date the Board determines your entitlement to a disability benefit.

(1) Terminated persons, either vested or non-vested, are not eligible for disability benefits.

(2) If you voluntarily terminate your employment either before or after filing an application for disability benefits, you are not eligible for disability benefits.

(3) If you are terminated by the City for any reason other than for medical reasons, either before or after you file an application for disability benefits, you are not eligible for disability benefits.

(4) The only exception to (1) above is:

(a) If you are terminated by the City for medical reasons and you have already applied for disability benefits before the medical termination, or;

(b) If you are terminated by the City for medical reasons and you apply within 30 days after your medical termination date.

If either (4)(a), or (4)(b) above applies, your application will be processed and fully considered by the board.

WAIVER OF RIGHT TO PRIVACY AND AUTHORIZATION FOR PUBLIC DISCLOSURE OF MEDICAL RECORDS

By requesting disability benefits from the City of North Port Police Officers' Pension - Local Option Trust Fund, I understand and acknowledge that my medical, physical, psychological or psychiatric condition must be discussed by the Board of Trustees and the amount of my personal account activities and potential benefit levels within the Fund must also be discussed by the Board.

By applying for the disability benefits and the signing of this waiver and authorization, I hereby waive any right to privacy to all medical records, medical claims records and all other information required to be disclosed to or discussed by the Board of Trustees for the evaluation and determination of my claim and authorize all of such being disclosed as public records.

I, THE UNDERSIGNED APPLICANT FOR DISABILITY BENEFITS FROM THE CITY OF NORTH PORT POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND, HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

Member's Signature Date

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

AFFIDAVIT OF DISABILITY BENEFIT RECIPIENT
(Not to be used with Application for Disability Retirement)

Before me, the undersigned authority, personally appeared _____, who being duly sworn deposes and says:

1. I am currently receiving disability retirement benefits from the City of North Port Police Officers' Pension - Local Option Trust Fund.

2. In the immediately preceding calendar year, I received income from the following sources:

a.	Workers' Compensation.	Yes [ ]	No [ ]
b.	Any employer.	Yes [ ]	No [ ]
c.	Self-employment.	Yes [ ]	No [ ]
d.	Other earned income. If yes, please state the source.	Yes [ ]	No [ ]

3. My current employment involves the following physical activities:

4. The current status of the condition upon which my disability benefits are based and my limitations resulting from such condition are as follows:

5. I engage in the following sports and recreational activities:

6. Attached is my treating physician's report specifically and completely stating:

a. The status of the condition upon which my disability benefits are based.

b. That I remain totally and permanently disabled from rendering useful and efficient service as a police officer and the reasons therefor.

c. The restrictions and limitations resulting from such condition.

7. Attached is additional information that I deem relevant for the Board's consideration in reviewing my continued benefit entitlement. ____ yes ____ no

8. I authorize the Board to utilize this affidavit and any attachments in any public meetings it may have regarding my disability status. I further waive any statutory or common law right of privacy I may have in these records, if necessary to enable the Board to discuss these records in any public meetings in connection with my disability status.

_____
Signature

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me, by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped

My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

* **This form is to be completed only by those persons <u>currently</u> receiving disability benefits.**

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

AUTHORIZATION FOR PAYMENT FROM FUND

TO:

SUBJECT: Authorization from Board of Trustees for Payment from Fund

Name of Payee: _____

Social Security Number: _____

Address for Payment Purposes: _____

_____

Amount of Payment: _____

_____ Retirement benefit, payable monthly for life, first payment to be made _____, 20_____ and subsequent payments the first day of each month thereafter. (Upon death of the payee, please notify the Board of Trustees for further instruction concerning survivor benefits, if any.)

____ Retirement benefit, payable monthly for life, first payment to be made _____, 20_____ and subsequent payments the first day of each month thereafter, until _____, 20_____, upon which date all remaining monthly payments shall be reduced to $_____.

_____ Disability benefit, payable until terminated by further written notice from Board. (Upon death of the payee, please notify the Board of Trustees for further instruction concerning survivor benefits, if any.)

_____ Death Benefit, payable to Beneficiary of Member, first payment to be made _____, 20_____ and subsequent payments on the first day of each month, with the last payment on _____, 20_____. (Upon the death of the payee, please notify the Board for further instructions.)

_____ Lump sum amount of $_____ (Member Contributions, PLOP, DROP, etc) (If Refund of Member Contributions, includes $_____ pretax and $_____ after tax)

The foregoing authorization and direction for payment has been made pursuant to directions and authority of the Board of Trustees.

BOARD OF TRUSTEES

By:_____

Date of Issuance: _____

(1 copy for Disbursing Agent, 1 copy for Board)

PF-7
03-01-15

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND
MEMBER'S ELECTION OF BENEFIT OPTION
(Service Retirements and Terminated Vested)

I, _____, have received the calculation of my retirement benefit options and I elect retirement benefits payable as follows:

A. **PARTIAL LUMP SUM BENEFIT.** A lump sum benefit of 10%, 15%, 20% or 25% of the value of my total benefit which will reduce the benefits paid under B below.

_____ I elect a partial lump sum benefit of _____% equal to $_____.
Enter $0 if no lump sum is elected or if you are entering the DROP.

B. In addition to any partial lump sum benefit selected in A. above, I elect to receive a benefit under the following option (initial one):

_____ **NORMAL FORM, TEN YEAR CERTAIN AND LIFE ANNUITY** - These monthly benefits are paid to the retiree until death. If the retiree dies before 10 years from the date of retirement, the benefits continue to the surviving beneficiary for the balance of the 10 year period. (If the retiree lives beyond the 10 year period, no benefits will be paid to the surviving beneficiary upon the retiree's death.)

Monthly amount $ _____

Please indicate the name of your beneficiary: _____
(Member's Designation of Beneficiary (PF-3) must be completed to confirm this designation)

_____ **LIFE ANNUITY** - These benefits are paid to the retiree for as long as he or she lives.

Monthly amount $ _____

_____ **JOINT AND SURVIVOR** - These monthly benefits are paid to the retiree until death. At death, the applicable percentage will continue to the retiree's joint annuitant until his or her death.

Retiree's Amount $_____ Percentage - circle one (100%, 75%, 66-2/3%, 50%)

Joint Annuitant's Amount $_____
(Name of Joint Annuitant _____)

_____ **SOCIAL SECURITY OPTION** - These benefits provide for a larger amount to be paid to a social security eligibility date determined by the member and a reduced amount thereafter, with benefits ceasing upon the death of the Retiree.

Amount $_____ paid to _____ and $_____, thereafter, until death.
(date)

Signature: _____ Date: _____

STATE OF _____
COUNTY OF _____
The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known ____ OR Produced Identification ____. Type of Identification Produced: _____.

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

MEMBER'S ELECTION OF BENEFIT OPTION
(Disability Retirements Only)

I, _____, have received the calculation of my retirement benefit options and I elect retirement benefits payable under the following option (initial one):

_____ **NORMAL FORM, TEN YEAR CERTAIN AND LIFE ANNUITY** - These monthly benefits are paid to the retiree until death. If the retiree dies before 10 years from the date of retirement, the benefits continue to the surviving beneficiary for the balance of the 10 year period. (If the retiree lives beyond the 10 year period, no benefits will be paid to the surviving beneficiary upon the retiree's death.)

Monthly amount $_____

Please indicate the name of your beneficiary: _____
(Member's Designation of Beneficiary (PF-3) must be completed to confirm this designation)

_____ **LIFE ANNUITY** - These benefits are paid to the retiree for as long as he or she lives.

Monthly amount $_____

_____ **JOINT AND SURVIVOR** - These monthly benefits are paid to the retiree until death. At death, the applicable percentage will continue to the retiree's joint annuitant until his or her death.

Retiree's Amount $_____ Percentage - circle one (100%, 75%, 66-2/3%, 50%)

Joint Annuitant's Amount $_____

(Name of Joint Annuitant _____)

Signature: _____ Date: _____

STATE OF _____
COUNTY OF _____
The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____ _____
Notary Public Name typed, printed or stamped
My Commission Expires: _____

Personally known ____ OR Produced Identification ____. Type of Identification Produced:_____.

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

CONFIRMATION OF RECEIPT OF RETIREMENT BENEFITS

The undersigned hereby confirms that he or she is currently receiving monthly retirement benefits from the City of North Port Police Officers' Pension - Local Option Trust Fund and that his or her entitlement to receive such benefits has not changed since benefits began.

_____ _____
Retiree, Beneficiary, Joint Pensioner (Circle One) (Name Printed) Social Security Number

_____ _____
Date Telephone Number

_____ _____
Current Address E-Mail Address

_____ _____
City / State / Zip Signature

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me, by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

THIS FORM MUST BE SIGNED PERSONALLY BY THE RETIREE, BENEFICIARY OR JOINT PENSIONER AND RETURNED, OR IF NOT SIGNED BY THE RETIREE, BENEFICIARY OR JOINT PENSIONER, A LETTER OF EXPLANATION FOR SUCH FAILURE MUST BE RETURNED WITH THIS FORM, TO:

City of North Port Police Officers' Pension - Local Option Trust Fund
Pension Resource Center
4100 Center Pointe Drive, Suite 108
Fort Myers, Florida 33916

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

FAILURE TO PROPERLY COMPLETE AND RETURN THIS FORM MAY RESULT IN A DISCONTINUATION OF BENEFITS.

PF-11
03-31-20

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

ELECTION TO LEAVE MEMBER CONTRIBUTIONS DEPOSITED IN FUND

I, _____, have separated employment with the City of North Port and I elect to leave my contributions deposited in the Fund. I understand that such money shall remain on deposit with the Fund until such time as I shall file a written request to the Board for a refund.

_____
Member's Signature

_____
Date

_____
Date of Birth

PF-12
01-15-08

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

RETURN OF CONTRIBUTIONS TO VESTED MEMBER
AND WAIVER OF RIGHTS AND BENEFITS

I, _____, the undersigned member of the City of North Port Police Officers' Pension - Local Option Trust Fund, hereby request return of my accumulated employee contributions in the amount of $_____. I understand that I am fully vested in the pension system. This means that I would be entitled to benefits from the system as provided for in the Pension Plan documents if I were not withdrawing my accumulated employee contributions.

I understand that by accepting a return of my accumulated employee contributions, I waive, release and relinquish all my rights and benefits under the City of North Port Police Officers' Pension - Local Option Trust Fund. I also understand that if I return to service with the City after accepting a return of my accumulated employee contributions, I may be forever barred from restoring periods of prior credited service that I may otherwise be entitled to if I were not withdrawing my accumulated employee contributions, except to the extent provided for in the Plan which is in effect at the time of my re-employment.

I have had a full and complete opportunity to consider the consequences of this return of accumulated employee contributions and waiver of rights and benefits. I make this decision freely and voluntarily. I hereby waive, release and relinquish forever all rights, benefits, claims and causes of action of every kind and description from the City of North Port Police Officers' Pension - Local Option Trust Fund; its Board of Trustees; agents; servants and employees, except for the return of my accumulated employee contributions.

I further certify that I am over the age of 18 years and otherwise competent to enter into binding agreements and that I have received the Special Tax Notice Regarding Plan Payments.

_____
Member's Signature

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped

My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE YOU SIGN, BE SURE YOU UNDERSTAND YOUR RIGHTS!

PF-13
03-31-20

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

RETURN OF CONTRIBUTIONS TO NON-VESTED MEMBER AND WAIVER OF RIGHTS AND BENEFITS

I, _____, the undersigned member of the City of North Port Police Officers' Pension - Local Option Trust Fund, hereby request return of my accumulated employee contributions in the amount of $_____.

I understand that by accepting a return of my accumulated employee contributions, I waive, release and relinquish all my rights and benefits under the City of North Port Police Officers' Pension - Local Option Trust Fund. I also understand that if I return to service with the City after accepting a return of my accumulated employee contributions, I may be forever barred from restoring periods of prior credited service that I may otherwise be entitled to if I were not withdrawing my accumulated employee contributions, except to the extent provided for in the Plan which is in effect at the time of my re-employment.

I have had a full and complete opportunity to consider the consequences of this return of my accumulated employee contributions and waiver, release and relinquishment of all my rights and benefits under the City of North Port Police Officers' Pension - Local Option Trust Fund. I make this decision freely and voluntarily. I hereby waive, release and relinquish forever all rights, benefits, claims and causes of action of every kind and description from the City of North Port Police Officers' Pension - Local Option Trust Fund; its Board of Trustees; agents; servants and employees, except for the return of my employee contributions.

I further certify that I am over the age of 18 years and otherwise competent to enter into binding agreements and that I have received the Special Tax Notice Regarding Plan Payments.

_____
Member's Signature

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped

My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced:_____.

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE YOU SIGN, BE SURE YOU UNDERSTAND YOUR RIGHTS!

PF-14
03-31-20

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS

You are receiving this notice because all or a portion of a payment you are receiving from the City of North Port Police Officers' Pension - Local Option Trust Fund is eligible to be rolled over to an IRA or an employer plan. This notice is intended to help you decide whether to do such a rollover.

Rules that apply to most payments from a plan are described in the "General Information About Rollovers" section. Special rules that only apply in certain circumstances are described in the "Special Rules and Options" section.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes?

You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59 ½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (unless an exception such as the Public Safety Officer exception, applies). If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (generally, distributions made before age 59½), unless an exception applies.

What types of retirement accounts and plans may accept my rollover?

You may rollover the payment to either an IRA (an Individual Retirement Account or Individual Retirement Annuity) or an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that hold the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover?

There are two ways to do a rollover. You can do either a direct rollover or a 60-day rollover.

1. If you do a direct rollover, the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

2. If you do not do a direct rollover, you may still do a rollover by making a deposit into an IRA or eligible employer plan that will accept it. Generally, you will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes. This means that, in order to rollover the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not rollover the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59 ½ (unless an exception applies).

How much may I rollover?

If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Certain payments spread over a period of at least 10 years or over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary);
- Required minimum distributions after age 70 ½ (or after death); and
- Corrective distributions of contributions that exceed tax law limitations.

The Plan administrator or the payor can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions?

If you are under age 59 ½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax applies to the part of the distribution that you must include in income and is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of separation;
- Payments that start after you separate from service if paid at least annually in equal or close to equal amounts over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary);
- Payments from a governmental plan made after you separate from service if you are a qualified public safety employee and you will be at least age 50 in the year of the separation;
- Payments made due to disability;
- Payments after your death;
- Corrective distributions of contributions that exceed tax limitations;
- Payments made directly to the government to satisfy a federal tax levy;
- Payments made under a qualified domestic relations order (QDRO);
- Certain payments made while you are on active duty, if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days;

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA?

If you receive a payment from an IRA when you are under age 59 ½, you will have to pay the 10% additional income tax on early distributions on the part of the distribution that you must include in income, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- The exception for payments made after you separate from service if you will be at least age 55 in the year of separation (or age 50 for qualified public safety employees) does not apply.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- The exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe State income taxes?

This notice does not describe any State or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If your payment includes after-tax contributions

After-tax contributions included in a payment are not taxed. If a payment is only part of your benefit, an allocable portion of your after-tax contributions is included in the payment, so you cannot take a payment of only after-tax contributions. In addition, special rules apply when you do a rollover, as described below.

You may roll over to an IRA a payment that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRA's (in order to determine your taxable income for later payments from the IRA's). If you do a direct rollover of only a portion of the amount paid from the Plan and at the same time the rest is paid to you, the portion directly rolled over consists first of the amount that would be taxable if not rolled over. For example, assume are you receiving a distribution of $12,000, of which $2,000 is after-tax contributions. In this case, if you directly roll over $10,000 to an IRA that is not a Roth IRA, no amount is taxable because the $2,000 amount not directly rolled over is treated as being after-tax contributions. If you do a direct rollover of the entire amount paid from the Plan to two or more destinations at the same time, you can choose which destination receives the after-tax contributions.

If you do a 60-day rollover to an IRA of only a portion of a payment made to you, the after-tax contributions are treated as rolled over last. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions, and no part of the distribution is directly rolled over. In this case, if you roll over $10,000 to an IRA that is not a Roth IRA in a 60-day rollover, no amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions.

You may roll over to an employer plan all of a payment that includes after-tax contributions, but only through a direct rollover (and only if the receiving plan separately accounts for after-tax contributions and is not a governmental section 457(b) plan). You can do a 60-day rollover to an employer plan of part of a payment that includes after-tax contributions, but only up to the amount of the payment that would be taxable if not rolled over.

If you miss the 60-day rollover deadline

Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. Under certain circumstances, you may claim eligibility for a waiver of the 60-day rollover deadline by making a written self-certification. Otherwise, to apply for a waiver from the IRS, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*

If you were born on or before January 1, 1936

If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income.*

If you are an eligible retired public safety officer and your payment is used to pay for health coverage or qualified long term care insurance

If the Plan is a governmental plan, you retired as a public safety officer, and your retirement was by reason of disability or was after normal retirement age, you can exclude from your taxable income Plan payments paid directly as premiums to an accident or health plan (or a qualified long-term care insurance contract) that your employer maintains for you, your spouse, or your dependents, up to a maximum of $3,000 annually. For this purpose, a public safety officer is a law enforcement officer, firefighter, chaplain, or member of a rescue squad or ambulance crew.

If you roll over your payment to a Roth IRA

If you roll over a payment from the Plan to a Roth IRA, a special rule applies under which the amount of the payment rolled over (reduced by any after-tax amounts) will be taxed. However, the 10% additional income tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within 5 years, counting from January 1 of the year of the rollover).

If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age 59 ½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to $10,000), and after you have had a Roth IRA for at least 5 years. In applying this 5-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*.

If you are not a Plan Participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you were born on or before January 1, 1936" applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse. If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59 ½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70 ½.

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been 70 ½.

If you are a surviving beneficiary other than a spouse. If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA. Payments from the inherited IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA.

Payments under a qualified domestic relations order. If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options and the same tax treatment that the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). However, payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

If you are a nonresident alien

If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRA Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

Other special rules

If a payment is one in a series of payments for less than 10 years, your choice whether to make a direct rollover will apply to all later payments in the series (unless you make a different choice for later payments).

If your payments for the year are less than $200 the Plan is not required to allow you to do a direct rollover and is not required to withhold federal income taxes. However, you may do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information on special rollover rights related to the U.S. Armed Forces, see IRS Publication 3, *Armed Forces' Tax Guide*. You also may have special rollover rights if you were affected by a federally declared disaster (or similar event), or if you received a distribution on account of a disaster. For more information on special rollover rights related to disaster relief, see the IRS website at www.irs.gov.

FOR MORE INFORMATION

You may wish to consult with the Plan administrator or a professional tax advisor before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in: IRS Publication 575, *Pension and Annuity Income*: IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*; IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at www.irs.gov, or by calling 1-800-TAX-FORM.

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

CERTIFICATION OF RECEIPT

I, _____, hereby make application under the provisions of the City of North Port Police Officers' Pension - Local Option Trust Fund, for a lump sum distribution of my pension contributions.

I hereby acknowledge that I have received the SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS and the LUMP SUM DISTRIBUTION ELECTION FORM on this _____day of _____, 20_____.

The SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS gives information regarding my options for a lump sum distribution from the Pension Plan.

I understand that in accordance with Federal law, my lump sum distribution may not be distributed more than 180 days after receipt of the notice. I further have been informed and understand that I have at least 30 days to consider the options set forth in the above described Special Tax Notice, but that I may waive the 30 day period if I feel I have had the opportunity to make an informed decision.

_____ _____
Signature Date

Address:_____

_____

IT IS RECOMMENDED THAT YOU CONSULT YOUR TAX ADVISOR CONCERNING THIS MATTER.

NO DISTRIBUTION WILL BE MADE UNTIL THIS FORM AND THE LUMP SUM DISTRIBUTION ELECTION FORM ARE RECEIVED BY THE BOARD OF TRUSTEES AT:

City of North Port Police Officers' Pension - Local Option Trust Fund
Pension Resource Center
4100 Center Pointe Drive, Suite 108
Fort Myers, Florida 33916

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST

LUMP SUM DISTRIBUTION ELECTION FORM

To be completed by Plan Member or Beneficiary (Transferor) with regard to the distribution to be received from the City of North Port Police Officers' Pension - Local Option Trust Fund, (the "System"):

Taxable Amount $_____ Non-taxable Amount $_____
Total Amount $_____

I. Please initial option A, B or C below:

☐ A. The System is directed to make full payment to me, less any applicable withholding described in the Special Tax Notice received with this election form.

☐ B. The System is directed to mail ____% of the taxable portion of my distribution to ____ _____ (Name of First Trustee or Plan) and ____% of the taxable portion of my distribution to _____ (Name of Second Trustee or Plan) for deposit in accordance with the rollover provisions. Any non-taxable portion will be:

_____ paid directly to me.

_____ rolled over to the First/Second Trustee or Plan (to traditional IRA, Roth IRA or 401(a) plan) *

☐ C. The System is directed to mail $_____ of my distribution to _____ _____(Name of Trustee or Plan) for deposit in accordance with the rollover provisions. The remainder of the taxable portion less any applicable withholding described in the Special Tax Notice received with this election form, plus the non-taxable portion, will be paid directly to me. *

*You will be taxed on rollovers to a Roth IRA.

NOTE: A surviving spouse may elect any option the deceased member could have made. A non-spouse beneficiary may only rollover to a regular IRA or Roth IRA and cannot rollover the payment himself.

_____ _____
Signature of Member or Beneficiary Social Security Number

_____ _____
Printed Name of Member or Beneficiary Date

The Agreement of Receiving Trustee or Plan below must be completed if Option B or C is selected.

II. Acknowledgment where election completed prior to 30 days after receipt of Special Tax Notice:

I acknowledge that I have had the opportunity to make an informed decision regarding my options, that I have been given the chance to consider the decision whether to elect a direct rollover for at least 30 days after my receipt of the special tax notice and that I have been provided with information clearly indicating that I have at least 30 days to make the decision, and I hereby waive the 30 day waiting period and elect an immediate distribution in accordance with my selection in I. above.

_____ _____
Signature of Member or Beneficiary Date

To be completed by the Authorized representative of the receiving Plan or IRA:

AGREEMENT OF RECEIVING TRUSTEE OR PLAN

In accordance with the above authorization of the Transferor, we agree to deposit the forthcoming rollover amount from the City of North Port Police Officers' Pension - Local Option Trust Fund into the following plan or account:

Type of Plan or Account receiving rollover (check one):

* _____ 401(a) [401(k), profit-sharing plan, defined benefit plan, money purchase plan, other "eligible employer plan"]

_____ 403(a) [annuity plan]

_____ 403(b) [tax-sheltered annuity]

_____ 457(b) [eligible deferred compensation plan maintained by government employer]

_____ 408(a) [Traditional IRA (not Simple IRA or a Coverdell Education Savings Account)]

_____ 408A [Roth IRA]

* If rollover includes after-tax contributions to a 401(a) eligible employer plan, the receiving 401(a) plan hereby agrees to accept such rollovers and agrees to separately account for such amounts rolled over including separate accounting for the after-tax employee contributions and earnings on these contributions.

NOTE: A surviving spouse may elect any option the deceased member could have made. A non-spouse beneficiary may only rollover to a regular IRA or Roth IRA and cannot rollover the payment himself.

_____ _____

Plan or Account Authorized Signature

_____

Typed Name and Title of Authorized Representative

_____ _____

Mailing Address Date

_____

City State Zip Code Phone Number

Return to:

City of North Port Police Officers' Pension - Local Option Trust
4100 Center Pointe Dr., Suite 108
Fort Myers, Florida 33916

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

CITY OF NORTH PORT POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

REQUEST FOR SERVICE CREDIT COST INFORMATION FOR MILITARY SERVICE

STEP 1 - COMPLETE SECTION A.

If we have provided cost information to you in the past for this service credit, check the "Yes" box and indicate the date your request was submitted. If you have submitted a retirement application, check the "Yes" box and indicate your planned retirement date.

Part 1 Fill in your current mailing information.

Part 2 List your active duty military service dates from your Military Certification.

Part 3 Sign and date the request form.

STEP 2 - SUBMIT THE COMPLETED REQUEST FORM.

- Make copy for your records.
- Attach a copy of your military discharge documents for all active duty dates (DD-214, Certification of Military Service Record, etc.)
- Mail the original to the Board's address listed below with a check for $_____, made payable to the Board.

SECTION A: DOCUMENTATION OF SERVICE (to be completed by member)

Have you requested this cost information before? ☐ Yes ☐ No

If yes, list date request was submitted:_____

Have you submitted a retirement application? ☐ Yes ☐ No

Have you purchased credited service for this military service in any other plan? ☐ Yes ☐ No

Part 1 Member information

Name Social Security Number

Former Name (if applicable) Daytime Phone

Mailing Address City State Zip

Part 2 Military Active Duty Service Dates (attach certification)

Armed Forces Branch Enlistment Date (month/day/year) Discharge Date (month/day/year)

Part 3 Certification

I understand that if I intend to rollover funds from another pension source in order to purchase all or part of this service credit, I must complete Form PF-20, Rollover Request/Certification. If I do not submit Form PF-20, my purchase will be deemed to have been made with after-tax money and not tax deferred rollover funds.

I hereby acknowledge and certify that the above information is true and correct.

Member's Signature Date

Mail To: North Port Police Officers' Pension - Local Option Trust Fund
Pension Resource Center
4100 Center Pointe Dr., Suite 108
Fort Myers, Florida 33916

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

CITY OF NORTH PORT POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

REQUEST FOR SERVICE CREDIT COST INFORMATION FOR PRIOR POLICE SERVICE

STEP 1 - COMPLETE SECTION A.

If we have provided cost information to you in the past for this service credit, check the "Yes" box and indicate the date your request was submitted. If you have submitted a retirement application, check the "Yes" box and indicate your planned retirement date.

Part 1 Fill in your current mailing information.

Part 2 List your prior public service dates of employment.

Part 3 Sign and date the request form.

STEP 2 - SUBMIT THE COMPLETED REQUEST FORM.

- Make copy for your records.
- Attach a completed Prior Public Employer Verification form for each prior public employer for which you are requesting service credit.
- Mail the original to the Board's address listed below with a check for $_____, made payable to the Board.

SECTION A: DOCUMENTATION OF SERVICE (to be completed by member)

Have you requested this cost information before? ☐ Yes ☐ No

If yes, list date request was submitted:_____

Have you submitted a retirement application? ☐ Yes ☐ No

Have you purchased or are you receiving credited service for this prior public service in any other plan? ☐ Yes ☐ No

Part 1 Member information

_____

Name Social Security Number

_____

Former Name (if applicable)

_____

Daytime Phone

_____

Mailing Address City State Zip

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

Part 2

I understand that I may claim retirement credit for police officer service that was earned in another public pension system provided I will not be eligible to receive a benefit in that public pension system. I was employed by the following employer(s) on the date(s) indicated:

Prior Public Employer	Employment Dates
_____	_____
_____	_____
_____	_____
_____	_____

I was a certified police officer during all periods listed above.

Part 3 Certification

I understand that if I intend to rollover funds from another pension source in order to purchase all or part of this service credit, I must complete Form PF-20, Rollover Request/Certification. If I do not submit Form PF-20, my purchase will be deemed to have been made with after-tax money and not tax deferred rollover funds.

I hereby certify that the above information is true and correct and authorize the administrator of the applicable retirement system to provide the City of North Port Police Officers' Pension - Local Option Trust Fund with the information requested in Section B and any other data that they may require.

_____

Member's Signature Date

Please return completed form to:

North Port Police Officers' Pension - Local Option Trust Fund
Pension Resource Center
4100 Center Pointe Dr., Suite 108
Fort Myers, Florida 33916

In no event may Credited Service be purchased for prior service with any other eligible public employer, if such prior service forms or will form the basis of a retirement benefit or pension from a different employer's retirement system or plan.

SECTION B: PRIOR PUBLIC EMPLOYER SERVICE VERIFICATION FORM

Member Name: _____ Member SS#: _____

Maiden or Other Names Used: _____ Birth date: _____

Please certify the dates of retirement covered employment. Florida law does not allow members to receive credit for prior public employment in both the City of North Port Police Officers' Pension - Local Option Trust Fund and a different employer's public pension system. Please answer the following questions and return this form so we may determine the member's eligibility to purchase prior public service credit.

Dates of Service Mo/Day/Yr (MM/DD/YY) From	**To**	**# Mos Worked**	**Full-time Employment?**	**Certified Police Officer?**
			____ Yes ____ No	____ Yes ____ No
			____ Yes ____ No	___ Yes ____ No
			____ Yes ____ No	____ Yes ____ No
			____ Yes ____ No	____ Yes ____ No
			____ Yes ____ No	____ Yes ____ No

1. Is your pension plan a defined benefit plan? ____ Yes ____ No
2. Is your pension plan a defined contribution plan? ____ Yes ____ No
   a. If your plan if a defined contribution plan, were employer contributions made on the individual's behalf? ____ Yes ____ No
   b. If yes, what is the status of those contributions?_____
3. Is the member eligible to receive a benefit from your system, now or in the future? ____ Yes ____ No
4. Does the member have credit in your system for service in another employers' plan? ____ Yes ____ No

   If yes, please list the system and year(s) below:

   System: _____ From:_____ To: _____
5. Has the member closed his retirement account? ____ Yes ____ No
   a. If no, please explain _____
   b. If applicable, when were the member's contributions withdrawn? _____/_____/_____

I certify that the above information was taken from the official records of _____ _____ (Name of system), which is a public retirement or pension system.

Signature: _____ Phone: _____

Print Name: _____ Address: _____

Title: _____ Date: _____

Name of Responding Agency:_____

CITY OF NORTH PORT POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

ROLLOVER REQUEST/CERTIFICATION

NOTE: Form PF-18, Request for Service Credit Cost Information for Military Service, and/or Form PF-19, Request for Service Credit Cost Information for Prior Police Service, must be submitted and the purchase of credited service must be approved prior to any rollover of funds.

PART A: THIS SECTION IS TO BE COMPLETED BY THE MEMBER

Member Name: _____ SS#: _____

Address/City/State: _____ Zip: _____

Telephone Number: _____ (Work) _____

(Home) _____

I understand that the City of North Port Police Officers' Pension - Local Option Trust Fund is a tax qualified defined benefit plan and may accept rollovers from qualified 401(a) plans (401k, profit sharing plan, defined benefit plans, money purchase plans or other eligible employer plans) 403(a) annuity plans, 403(b) tax sheltered annuities, eligible plans under Section 457(b) maintained by state, political subdivisions of states, or any agency or instrumentality of a state or political subdivision of a state or traditional IRAs (not Roth IRA, Simple IRA or Coverdell Education Savings Account). Rollovers can only be used to purchase permissible credited service as provided for in the City of North Port Police Officers' Pension - Local Option Trust Fund.

I choose to rollover $ _____ to the City of North Port Police Officers' Pension - Local Option Trust Fund.

I understand that the City of North Port Police Officers' Pension - Local Option Trust Fund will rely on the information contained on this Rollover Request/Certification in approving this rollover.

Signature _____ Date _____

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

PART B: THIS SECTION IS TO BE COMPLETED BY THE PLAN ADMINISTRATOR OR TRUSTEE OF THE PLAN FROM WHICH THE ROLLOVER IS BEING MADE

A. I certify the funds being rolled over are from a:

_____ 401(a) [401k, profit sharing plan, defined benefit plan, money purchase plan, other eligible employer plan] **CIRCLE ONE**

_____ 403(a) [annuity plan]

_____ 403(b) [tax sheltered annuity]

_____ 457(b) [eligible deferred compensation plan maintained by government employer]

_____ 408(a) [traditional IRA, not Roth IRA, Simple IRA or a Coverdell Education Savings Account]

B. I certify that these funds are an eligible rollover distribution as defined by the Internal Revenue Code and the entire rollover amount would be otherwise includible in gross income if not rolled over.

C. ☐ I certify that I am the Plan Administrator

☐ I certify that I am the IRA Trustee

☐ I certify that I am the Qualified Plan Trustee

D. _____ Attached is a check in the amount of $_____ as a rollover distribution.

_____ A check in the amount of $_____ will be sent under separate cover.

_____ A check in the amount of $_____, representing a net distribution from the above eligible fund, less applicable taxes, was provided to _____, on _____, 20____.
Name of Member
The gross distribution amount was $_____.

_____ _____
Plan or Account Authorized Signature

_____
Typed Name and Title of Authorized Representative

_____ _____
Mailing Address Date

_____
City State Zip

Please return completed form to:

North Port Police Officers' Pension - Local Option Trust Fund
Pension Resource Center
4100 Center Pointe Dr., Suite 108
Fort Myers, Florida 33916

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

AGREEMENT CONCERNING DEDUCTION FROM RETIREMENT BENEFITS FOR QUALIFIED HEALTH INSURANCE PREMIUMS

This Agreement is hereby made by the City of North Port ("City") and the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund ("Pension Fund").

The purpose of this Agreement is to efficiently implement the provisions of Section 845 of the Pension Protection Act of 2006.

The Pension Fund agrees to begin to or continue to deduct premiums from retired members for qualified health insurance premiums.

For purposes of Section 845 of the Pension Protection Act of 2006, the City agrees to serve as the Pension Fund's intermediary to make payment of the premiums deducted from a member's retirement benefit by the Pension Fund directly to the provider(s) of the qualified health insurance plan.

The City agrees that the City will not pay any such deducted premium to a member instead of directly to the provider(s) of the qualified health insurance plan.

Dated this _____ day of _____, 20_____ .

CITY OF NORTH PORT

By: _____

CITY OF NORTH PORT POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

By: _____
As Chairman

ATTEST:

By: _____
As Secretary

PF-21
01-15-08

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

AUTHORIZATION FOR DEDUCTION FROM RETIREMENT BENEFITS

WHEREAS, Section 185.05(6), Florida Statutes, provides that the Board of Trustees may, upon written request by the retiree of the plan, withhold from the monthly retirement payment those funds that are necessary to pay for benefits received through the governmental entity from which the employee retired **or** to pay for accident, health and long term care insurance from an insurance carrier not associated with the governmental entity from which the employee retired; and;

WHEREAS, Section 408 of the Internal Revenue Code was amended by the Pension Protection Act of 2006 to provide that "eligible retired public safety officers" will receive up to a $3,000 taxable income exclusion toward the cost of accident, health or long-term care insurance if payment of the premiums is made directly to the provider of the accident, health or long-term care insurance plan by deduction from a distribution from the eligible retirement plan;

1. Therefore, I, the undersigned retired police officer of the City of North Port do hereby authorize the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund and the custodian of the Fund to deduct from my monthly pension benefits from the City of North Port Police Officers' Pension - Local Option Trust Fund and to pay directly to either (initial one):

   _____A. the City of North Port, and in turn to the provider of accident, health or long-term care insurance, if applicable, those premiums necessary for the undersigned to maintain coverage with the health, accident, or long-term care insurance provided by the City of North Port to retired police officers and their spouses and dependents, which coverage I have elected to maintain. This authorization shall include any increases in the premiums for such insurance which I have elected to maintain coverage, or

   _____B. my insurance carrier, _____,
   Company Name
   _____,
   Company Address for Payments
   policy number_____ with a current monthly premium of $_____ representing the premium necessary for the undersigned to maintain coverage for the health, accident, or long-term care insurance provided by the named company to me and my spouse and/or dependents, which coverage I have elected to maintain. This authorization shall include any increases in the premiums for such insurance which I have elected to maintain coverage.

2. I hereby certify that I am a retired public safety officer as defined by 42 U.S.C. 3796b(9)(A), that I retired from the plan under Normal Retirement (Not Early) or Disability Retirement and I am not receiving a benefit as a terminated vested person.

3. This deduction shall take effect as soon as is administratively possible after directions are received by the Custodian for the Plan from the Board of Trustees, unless a later start date is directed.

4. This deduction shall continue to be in effect until I request that the Custodian for the Plan be given direction from the Board to cease this deduction, unless a later stop date is directed. The custodian shall cease the deduction as soon as is administratively possible.

5. I understand that:

A. Every effort will be made to maximize a retiree's annual tax free deductions under this program. However, due to rounding or changing of premiums, differences in alignment between calendar years, taxable years, benefit years and fiscal years, differences between the record keeping and invoicing procedures between the parties involved and due to other administrative matters beyond the control of the parties, neither the Board nor the City makes any guarantee that a retiree will receive the maximum tax free allowance for each benefit year.

B. This program is subject to change at any time based on Internal Revenue Service interpretations, changes to the PPA, or in the case that this program is found to be in conflict with other federal, state or local laws. In the event of a conflict between this program and governmental regulations, official interpretations, or other relevant legal decisions, this program shall be subordinate.

C. This program is furnished by the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund as a customer service to retired participants. Neither the Board nor the City of North Port accepts any liability and makes no guarantees regarding the tax implications of any health insurance premiums paid through this program. As always, retirees should consult with a professional tax advisor regarding matters of the taxability or non-taxability of pension and health insurance benefits.

D. The Board of Trustees reserves the right to require retirees participating under this program to pay any such costs as may be assessed by the fund custodian, the plan administrator or the qualified health insurance provider in the future for the processing, disbursement or acceptance of insurance policy premium payments.

E. I understand that the Retirement System is not responsible for lapsed premiums or lapsed insurance policy coverage or any other coverage or benefit issues that may arise between my insurance carrier and myself.

F. I take full responsibility for the accuracy and truth of all the information I have provided and certify that I am entitled to these benefits.

G. I understand that by electing to participate in the federal tax exclusion, I will be decreasing my federal taxable income. This tax exclusion may not apply to state taxation.

H. I understand that I may not request additional tax-preferred treatment of the applicable exclusion amount (up to $3,000.00 annually), from any other qualified retirement systems (i.e. Governmental defined benefit plans, or 403(b) plans).

I. I understand that the Retirement System is complying with federal law by withholding insurance premiums from my pension benefits. In doing so, the Retirement System is only performing an administrative function and is only responsible for payment of premiums, as required by law.

J. I understand that the health insurance premium withholding may affect tax withholding from my monthly pension annuity.

K. AS A CONDITION OF PARTICIPATION IN THIS PROGRAM, I ACCEPT ALL RESPONSIBILITY FOR TRUTH OF THE INFORMATION PROVIDED TO THE PLAN. IN ADDITION, IN CONSIDERATION OF PARTICIPATION, I AGREE THAT THE RETIREMENT SYSTEM, ITS STAFF OR ADVISORS, AND THE EMPLOYER HAVE NO LIABILITY FOR ANY ADDITIONAL TAX LIABILITY, INCLUDING INTEREST AND PENALTIES THAT MAY ARISE FROM PARTICIPATION.

AS THIS WAIVER INVOLVES MY LEGAL RIGHTS, I HAVE BEEN ADVISED TO SEEK COMPETENT LEGAL ADVICE PRIOR TO PARTICIPATING IN THE PROGRAM. I UNDERSTAND AND AGREE THAT I HAVE HAD A FULL OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND TO SEEK OUTSIDE ADVICE.

L. BY SIGNING THIS FORM, I AGREE THAT I WILL NOT MAKE ANY LEGAL CLAIM OF ANY KIND AGAINST THE RETIREMENT SYSTEM, ITS STAFF AND ADVISORS, AND THE EMPLOYER SHOULD MY PARTICIPATION IN THIS PROGRAM RESULT IN UNEXPECTED TAX LIABILITY TO ME, INCLUDING INTEREST AND PENALTIES. I UNDERSTAND THAT MY ABILITY TO PARTICIPATE IN THIS PROGRAM IS A VALUABLE BENEFIT FOR WHICH I AM WILLING TO SIGN THIS WAIVER OF ALL CLAIMS. I FURTHER RELEASE THE RETIREMENT SYSTEM, ITS STAFF AND ADVISORS, AND THE EMPLOYER FROM ANY LIABILITY ARISING FROM THE ADMINISTRATION OF PAYMENTS TO ANY INSURER.

Dated: _____

_____
Print Name

_____
Signature

STATE OF _____
COUNTY OF:_____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this __ day of _____, 20_____ by _____.

_____
Notary Public

_____
Name typed, printed or stamped
My Commission Expires: _____

Personally known ___ OR Produced Identification ___. Type of Identification Produced:_____.

Return to:
City of North Port Police Officers' Pension - Local Option Trust Fund
Pension Resource Center
4100 Center Pointe Dr., Suite 108
Fort Myers, Florida 33916

CITY OF NORTH PORT POLICE OFFICERS' PENSION -
LOCAL OPTION TRUST FUND

CHANGE OR CONFIRMATION OF DESIGNATED JOINT ANNUITANT OR JOINT PENSIONER

Name of Employee: _____

Social Security Number: _____

Date of Employment: _____ Date of Birth: _____

Permanent Address: _____

_____

Daytime Phone Number: _____

A. _____ I wish to confirm my current joint annuitant.

Name of joint annuitant:_____

Relationship: _____

B. _____ I wish to change my current joint annuitant to:

Name of joint annuitant:_____

Relationship: _____

Social Security Number: _____

* Date of Birth: _____

Address: _____

* *Attach birth certificate or driver's license for proof of age*

If electing to designate a new Joint Annuitant, I hereby request that the Board of Trustees calculate my retirement options based on the information provided above. I understand that there will be charge for making this change and that the amount of my benefit may increase or decrease, depending on the age of my new joint pensioner.

I hereby certify that the preceding statements are true and correct to the best of my knowledge. I also certify that I will adhere to the requirements of the Plan. I understand a false statement may disqualify me for benefits.

This designation revokes any prior designation.

Signature: _____

Date: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was sworn before me this _____ day of _____, 20_____ by _____ who is personally known to me or who has procured _____ as identification, and who did take an oath.

_____
Notary Public

My commission expires:

"Pursuant to Section 119.071(5)(a)2., Florida Statutes, your social security number is requested for the purpose of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; the processing of retirement benefits; verification of retirement benefits; income reporting; or other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes."

CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

HEALTH CERTIFICATE

NOTE: This certificate MUST be signed and completed by a licensed physician. The Patient named below is the current Joint Annuitant who is being replaced with a new Joint Annuitant.

Name of Patient: _____

Date of Birth: _____

I, _____, hereby affirm that I am a licensed
(Name Printed)
physician and I am familiar with the medical history and current medical condition(s) of the Patient named above and that he/she is, to the best of my knowledge, free from any medical condition which represents an immediate threat to life and he/she is in reasonably good health.

_____
Physician signature

_____
Address

_____
City, State, Zip

_____
Date

(Date)

Mr. Douglas Beckendorf, Actuary
Bureau of Local Retirement Systems
P. O. Box 9000
Tallahassee, Florida 32315-9000

Re: City of North Port Police Officers' Pension - Local Option Trust Fund - Declaration of Returns

Dear Mr. Beckendorf:

On _____, ____, the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund, based on the advice of its investment professionals and/or actuary, determined that the total expected annual rate of investment return for our fund for the next year, the next several years, and the long-term thereafter, shall be _____%, net of investment related expenses. This determination is made in accordance with Section 112.661(9), Florida Statutes. We have enclosed supporting documentation.

Yours very truly,

(Chairman or Secretary of Board)

Enclosure

cc: Board Actuary
City Manager

(Date)

City Commission
City of North Port
c/o (Name and address of Person to receive letter; ie, City Manager, Finance Director)

Re: City of North Port Police Officers' Pension - Local Option Trust Fund - Annual Report of Investment Activity

Dear _____:

In accordance with Section 112.661(15), Florida Statutes, please find enclosed the annual report of investment activity of the City of North Port Police Officers' Pension - Local Option Trust Fund. This report includes investments in the portfolio as of September 30, ____ listed by class or type, book value, income earned and market value as of the stated date. This report must also be made available to the public.

Yours very truly,

Chairman or Secretary of Board

PL-2
01-15-08

(Date)

Mr. Douglas Beckendorf, Actuary
Bureau of Local Retirement Systems
P. O. Box 9000
Tallahassee, Florida 32315-9000

Re: City of North Port Police Officers' Pension - Local Option Trust Fund - Investment Policy Statement

Dear Mr. Beckendorf:

In accordance with Section 112.661(16), Florida Statutes, enclosed please find a copy of the revised Investment Policy Statement adopted by the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund.

Yours very truly,

Chairman or Secretary of Board

cc: Actuary
City of North Port

PL-3
07-27-17

(Date)

Name of Recipient

Re: City of North Port Police Officers' Pension - Local Option Trust Fund

Dear _____:

You recently received a Confirmation of Receipt of Retirement Benefits (PF-11) from the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund and you were requested to have this affidavit notarized and returned to the Board confirming that you are currently receiving retirement benefits from the pension plan and that your eligibility for those benefits continues. To date we have not received your completed confirmation.

The Board of Trustees has a fiduciary responsibility to be certain that only those persons who are eligible to receive benefits from the pension plan are receiving payments. In the past, we have had circumstances where a retiree passes away and his benefits continued to be paid either into a joint bank account or by check to persons who are not eligible for these benefits. Accordingly, the Board of Trustees has developed the system of sending to all retirees a confirmation of receipt of their benefits and, by requiring that the affidavit be executed in the presence of a Notary Public, the Board can confirm that the retiree is still alive and eligible for benefits. This is the reason you received the affidavit from the Board of Trustees.

Since we did not receive a completed affidavit from you, we are again requesting that you complete the enclosed affidavit and return it to the Board's recording secretary, _____, located at _____. In the event that you fail to complete and return the enclosed affidavit, the Board may be forced to set a hearing to determine whether or not you continue to be eligible for pension benefits. This will require you to make a personal appearance before the Board of Trustees in order for the Board to confirm your continuing right to receive benefits. Obviously, scheduling such a hearing would be an expense for the Board and an inconvenience to you. Therefore, we request your cooperation in completing the enclosed Confirmation of Receipt of Retirement Benefits and returning it to _____ as soon as possible.

I thank you in advance for your cooperation in this regard.

Yours very truly,

Chairman or Secretary of Board

enclosure

PL-4 (use with PF-11)
01-15-08

(Date)

_____, Finance Director
City of North Port

Re: City of North Port Police Officers' Pension - Local Option Trust Fund

Dear _____:

At the recommendation of the attorney for the Board of Trustees, the Board requested bids for and has now purchased a fiduciary insurance policy which will cover the pension plan for losses incurred as a result of fiduciary risks set forth in the policy. This policy does not duplicate and is in addition to coverage afforded by other policies currently in effect for the City of North Port.

The insurance policy covers not only the pension fund itself but also the individual trustees while acting in their fiduciary capacity. In order to protect the personal assets of the individual trustees, it is necessary to spend an additional $_____ so that the insurance company will "waive recourse" against the individual trustees. This means that if the pension fund should suffer a loss as a result of decisions or acts of one or more of the trustees which result in a loss to the pension fund, which loss is paid by the insurance company, the insurance company, by payment of this additional $_____ premium, agrees not to recover the loss by suing the individual trustees for their act or decision. If this additional coverage is not purchased, the personal assets of each individual trustee of the pension plan could be subject to a judgment which might be sought by the insurance company if the waiver of recourse is not purchased.

Legally, the $_____ premium for the waiver of recourse against the individual trustees cannot be paid directly out of the pension plan funds. The premium can only be paid by the employer (City of North Port), or the individual trustees themselves. Since trustees of the pension board act without compensation as a service to the community, it appears inappropriate to require the individual trustees to each pay $_____ in order to protect their personal assets from potential claims resulting from their voluntary service on the pension board. The Board has paid the additional $_____, at this time, to avoid a lapse in the policy. However, for legal reasons given, the Board would like to ask the City of North Port to agree to pay the $_____ premium for the waiver of recourse. Assuming that you agree, we would ask that the City's check in the amount of $_____ be made payable to the City of North Port Police Officers' Pension - Local Option Trust Fund and show that the check is for reimbursement for waiver of recourse coverage on the fiduciary liability insurance policy.

Should you have any questions regarding this matter, please feel free to contact me or the Board's attorney, Scott Christiansen at 941-377-2200.

Yours very truly,

Chairman or Secretary of Board

PL-5
03-31-20

(Date)

Name of Recipient

Re: City of North Port Police Officers' Pension - Local Option Trust Fund

Dear _____:

Failure to comply with this mandatory request will result in an interruption of your pension benefits.

Numerous letters have been sent to you requesting that you complete a Confirmation of Receipt of Retirement Benefits (PF-11) from the Board of Trustees of the City of North Port Police Officers' Pension - Local Option Trust Fund. You were requested to have this affidavit notarized and returned to the Board confirming that you are currently receiving retirement benefits from the pension plan and that your eligibility for those benefits continues. To date we have not received your completed PF-11 form.

The Board of Trustees has a fiduciary responsibility to be certain that only those persons who are eligible to receive benefits from the pension plan are receiving payments. This letter serves to inform you that a Hearing to determine continuation of your benefits will be held at the board meeting on Enter day, date, and time of meeting, located at the i.e. police department training room, then address.

If you submit the completed PF-11 form prior to the Hearing, the Hearing will be cancelled. However, if we do not receive the completed PF-11 form prior to the Hearing and you fail to attend, the Board will terminate your benefits beginning with the enter the first day of the month after the date of the hearing payment.

Please do not hesitate to contact the board at enter board contact phone number if you have any questions.

Yours very truly,

Chairman or Secretary of Board

enclosure

PL-6 (use after PL-4)
11-28-16