

**Florida Retirement System Pension Plan
Application for Survivor Benefits**

PO Box 9000
Tallahassee FL 32315-9000
(850) 488-5207
Toll Free: (877) 377-4347

Payee SSN _____

Payee Name _____ Birthdate _____ Date of Death _____

Applicant Name _____ Applicant SSN ____/____/____

Relationship to Member _____ Applicant Birthdate ____/____/____

Member Name _____

Applicant Home (____) _____ Applicant _____
Phone _____ Mailing _____

Work (____) _____ Address _____

I am applying for benefits from this retirement account. The following individual will be responsible for my affairs at my death:

Name _____ Relationship _____

Address _____

Phone (____) _____

This form must be signed and acknowledged before a notary public.

Applicant Signature (sign in the presence of a Notary) _____

Notary:

State of _____, County of _____ The above named person who has sworn to
and subscribed before me this ____ of _____ 20__ and who is personally known _____
or produced _____ identification.

Signature of Notary Public

Print, Type or Stamp Commissioned Name of Notary Public