TEACHERS' RETIREMENT SYSTEM OF FLORIDA APPLICATION FOR DISABILITY RETIREMENT

PO Box 9000 Tallahassee, FL 32315-9000 850-907-6500 Toll Free: 844-377-1888

	Fax: 850-	-410-2010
		Date
		SSN
In accordance with the provisions undersigned, a member of the Sys		peration of the Teachers' Retirement System of Florida, the pplication for disability retirement.
Present (or last) Employe	۲	
Name of Position Held		Date of Birth
() Option 1.	(Maximum Annuity with	no Refund to Beneficiary)
() Option 2.	(Reduced Annuity with F	Refund to Beneficiary)
() Option 3.	(Reduced Benefit to be continued to Surviving Spouse for Life)	
() Option 4.	(Reduced Benefit with o	ne-half Thereof to Continue to the Surviving Spouse for Life)
The beneficiary whom I should like (A beneficiary should be designate		refund under the option selected at my death is: selected)
Relationship	Name of Beneficiary	Date of Birth
Address		
I am () am not () receiving a municipality or other taxing district.		receive a pension or annuity from any other state, county, or
My services terminated or will term	ninate	19
	Signed (DO NO	DT PRINT)
	Address for Ch	leck
		Zin oodo
Assessed by Freedom		Zip code
Approved by Employer	Name	Title
APPLICANT MUST SIGN IN THE	PRESENCE OF NOTARY	Y PUBLIC
Notary:		
State of, Cour	nty of	The above named person who has sworn to and subscribed
before me this day of	20) and who is personally known or produced
	_identification.	
Signature of Notary Public		
	Print	Type or Stamp Commissioned Name of Notary Public