Senior Management Service Optional Annuity Program (SMSOAP)

Application for Refund of Voluntary Employee Contributions Only

Division of Retirement – OAP/ORP Section
PO Box 9000
Tallahassee, Florida 32315-9000

Phone: 850-778-4696 Toll-free: 877-378-7677 FAX: 850-410-2030

Email: orpdata@dms.MyFlorida.com

A. When to use Form OAP-REFUND.

This form is an application for the refund of only your voluntary employee contributions under the SMSOAP.

- Do not use this form for contract exchanges of contributions between SMSOAP-approved providers and products. You will need to contact your provider company for those forms.
- Do not use this form to redirect future contributions to a different provider. If you are not retiring, and wish to direct future contributions to a different provider, please submit Form **OAP-CHANGE**.
- If you are requesting a Required Minimum Distribution, please use Form **OAP-RMD**.
- Do not use this form to retire from the SMSOAP and request a distribution (including a rollover distribution) of employer and/or required employee contributions from your SMSOAP account. Use Form **OAP-RETIRE.**

B. Eligibility for Refund:

You are not eligible to access your SMSOAP voluntary employee contributions and related earnings until you terminate all employment relationships with all participating Florida Retirement System (FRS) employers for three full calendar months.

NOTE: There may be tax penalties if you access the funds prior to age 59-1/2.

C. Form Completion:

1. Complete Section I (Contact Information) and Section II (Member Certification) of the form. Your signature must be notarized.
2. Have your SMSOAP employer complete Section III (Employer Certification) of the form. Or you may also submit the form with your notarized signature to the Division of Retirement and we will obtain the employer certification.
3. Submit the completed form to the Division by fax, email, or U.S. Mail using the information provided at the top of the form.

Upon receipt of the completed form, the Division will verify your termination to determine your eligibility to receive a refund of your voluntary employee contributions. The Division will notify you if you are not eligible.

If your service provider gives you a form that requests a signature from the Division, indicate on the company form that Form OAP-REFUND will be sent to them by the Division.

Please contact the Division using the information at the top of this page or email orpdata@dms.myflorida.com if you have any questions.

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I. Contact Information:

Member Name: ______________________________ Member SSN: ______________________________

Home Mailing Address: ____

____

Home Phone: ________________________ Work Phone: ________________________

II. Member Certification: (sign in the presence of a Notary):

I am requesting a full or partial refund of **only** my voluntary employee contributions from my SMSOAP account. I understand that I cannot receive a refund from my SMSOAP account while I am employed in any capacity with any employer participating in the Florida Retirement System (FRS). I have terminated or will terminate all employment with all FRS employers on (date) ______________.

I understand that I am not eligible to receive a refund of my voluntary employee contributions from my SMSOAP account until I am terminated from all employment relationships with all FRS employers for three full calendar months in accordance with 121.035(5)(g), Florida Statutes. For example, if I terminate employment on June 6, the earliest that I am able to receive a refund of my voluntary employee contributions from my SMSOAP account is October 1.

I further understand that by requesting a refund of my voluntary employee contributions and earnings from my SMSOAP account, **I am not a RETIREE** of a state-administered retirement program.

Member 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 _____ day of ___________, ______, and who is personally known ___ or produced ____identification.

____ ____

Signature of Notary Public - State of _____________ Print, Type or Stamp Commissioned Name of Notary Public

III. Employer Certification:

This is to certify that the above named member was employed by this agency and will terminate, or has terminated on

____________________.

Agency Authorized Signature: ______________________________ Date signed: ________________________

Agency Name/Number: ____ Agency Phone: ________________

IV. Division of Retirement Certification:

Termination verified ☐ Yes No ☐

By: ______________________________________ Date: ________________________