TOWN OF DAVIE FIREFIGHTERS' PENSION FUND

BENEFICIARY DESIGNATION FORM

I. Participant:

Name of Participant:_____, _____ _____
(Last) (First) (Middle)

Social Security #:_____ - _____ - _____Date of Birth: ____/____/____

II. Beneficiary:

I hereby designate the following person (or persons) as my beneficiary(ies) entitled to receive any benefit due in the event of my death:

Name of Beneficiary: _____ Percentage:_____

Beneficiary's Social Security #: _____ - _____ - _____Relationship: _____

Date of Birth of Beneficiary: _____/_____/_____Sex of Beneficiary:Male _____ Female: _____

Address: _____
(Address) (Street)

_____
(City) (State) (Zip Code)

Telephone Number of Beneficiary: ( ) _____

Name of Beneficiary: _____ Percentage:_____

Beneficiary's Social Security #: _____ - _____ - _____Relationship: _____

Date of Birth of Beneficiary: _____/_____/_____Sex of Beneficiary:Male _____ Female: _____

Address: _____
(Address) (Street)

_____
(City) (State) (Zip Code)

Telephone Number of Beneficiary: ( ) _____

(Note that the total percentages for both beneficiaries may not exceed one hundred percent. You are permitted to list a child as a beneficiary, but the Pension Board may require the appointment of a guardian prior to payment of monies to a minor child. If a married member fails to designate his or her spouse, the benefit will be paid to the beneficiary. Failure to designate a spouse may result in a lower benefit for the non-spouse beneficiary. It is important that you update this form from time to time, as your family circumstances change.)

III. Contingent Beneficiary (To receive benefit if above named beneficiaries predecease member):

If the above named beneficiary(ies) dies before me, or is not available to receive any benefit due, I designate the following person(s) as the contingent beneficiary(ies) entitled to receive any benefits due:

Name of Contingent Beneficiary: _____ Percentage:_____

Beneficiary's Social Security #: _____ - _____ - _____Relationship: _____

Date of Birth of Beneficiary: _____/_____/_____Sex of Beneficiary:Male _____ Female: _____

Address: _____
(Address) (Street)

_____
(City) (State) (Zip Code)

Telephone Number of Contingent Beneficiary: ( ) _____

Name of Contingent Beneficiary: _____ Percentage:_____

Beneficiary's Social Security #: _____ - _____ - _____Relationship: _____

Date of Birth of Beneficiary: _____/_____/_____Sex of Beneficiary:Male _____ Female: _____

Address: _____
(Address) (Street)

_____
(City) (State) (Zip Code)

Telephone Number of Contingent Beneficiary: ( ) _____

(Note that the total percentages for both contingent beneficiaries may not exceed one hundred percent.)

This form takes the place of any other beneficiary form previously filed.

I understand that in the event of a service connected death, my surviving spouse shall be eligible to receive a pension equal to fifty (50%) of my average monthly earnings, plus five (5%) for each child, with a maximum aggregate monthly pension benefit of sixty (60%) percent. I further understand that this service connected death benefit is in lieu of a return of my contributions or any other death benefit.

_____
(Member's signature)

STATE OF FLORIDA
COUNTY OF BROWARD

The foregoing instrument was acknowledged before me this _____, day of _____, 20____, by_____, who is personally known to me or who has produced _____as identification and who did not take an oath.

_____
Name:
Notary Public
My Commission Expires:_____
Commission No:_____