DP-TEOC-2
10/07
Retired Payroll

Florida Retirement System Pension Plan
Deferred Retirement Option Program (DROP)
Elected Officer DROP Termination Notification

Retired Payroll Section
PO BOX 3090
Tallahassee, FL 32315-3090
Local: 850-487-4856 Toll Free: 1-877-738-3767

MEMBER NAME _____ **MEMBER SSN** _____

Your DROP termination date is _____. As an elected officer whose position is covered by the Elected Officers' Class (EOC) you may end your Deferred Retirement Option Program (DROP) participation without terminating your elected office as provided in s. 121.053(1)(b)(5), Florida Statutes. If you choose to continue your eligible elected employment after DROP participation ends you must acknowledge the following:

1. This provision applies only to employment as an elected official, in a position covered by the Florida Retirement System (FRS) EOC.
2. I cannot be paid monthly pension benefits or my accumulated DROP benefits until all FRS employment is terminated as provided in s. 121.021(39)(b), Florida Statutes.
3. At the conclusion of my participation, my DROP account will not accrue additional monthly benefits, but will continue to earn interest as provided in s. 121.053(1)(b)(5)(a), Florida Statutes, through the month of my elected employment termination.
4. My elected employment, from the calendar month after my DROP participation ends through the calendar month that my elected employment is terminated, is subject to the following:
   - Retirement contributions will not be required of my FRS employer; however, Health Insurance Subsidy (HIS) contributions will be required.
   - Renewed membership service credit will not be earned.
   - Retirement benefits for this period will be forfeited.
5. I understand that I may not enroll in DROP again.

MEMBER CERTIFICATION:
My **DROP participation** will end or has ended on _____. I have chosen to continue employment as an elected officer in a position covered by the EOC until the end of my current, consecutively held or succeeding term of office, OR an earlier resignation date of _____. I acknowledge that I have read and understand the above statements.

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 _____ 20 _____ and who is personally known _____ or produced _____ identification.

_____ _____
Signature of Notary Public Print, Type or Stamp Commissioned Name of Notary Public

EMPLOYER CERTIFICATION: TO BE COMPLETED BY AGENCY HEAD OR DESIGNATED REPRESENTATIVE:

I certify that the above **elected** member's **DROP participation** will terminate or has terminated on _____ with the Agency, who I am authorized to represent. I acknowledge that the member's post-DROP employment (from the calendar month following the month his/her DROP participation ended through the calendar month of his/her elected employment termination is subject to the following:

1. Retirement contributions will not be required.
2. Health Insurance Subsidy (HIS) contributions will be required.

I further certify that the above named elected official's anticipated employment termination date is _____.

Authorized Signature: _____ Position Title: _____

Print Name: _____ Phone Number: _____

Agency Name:_____ Agency #: _____ Date: _____