

**Florida Retirement System Pension Plan  
Deferred Retirement Option Program (DROPTerm)  
Elected Officer Employment Termination Notification**



PO Box 9000 Tallahassee, FL 32315-9000  
Local 850-907-6500 Toll Free 844-377-1888 Fax 850-410-2010

**MEMBER NAME:** \_\_\_\_\_ **MEMBER SSN:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

According to your request, your termination date as an elected official is \_\_\_\_\_. In order to receive your accumulated Deferred Retirement Option Program (DROPTerm) benefits and your monthly retirement benefits, your employment termination must be certified. This form must be completed by both you and an authorized representative of your Florida Retirement System (FRS) employer to verify your employment termination. The completed form must be returned to the Division of Retirement. Your FRS pension and accumulated DROPTerm benefits are subject to the following:

1. I understand that my DROPTerm benefits are an accumulation of monthly pension benefits and interest through the month of my DROPTerm participation end date. If my DROPTerm participation began before July 1, 2010, at the conclusion of my participation, my DROPTerm account did not accrue additional monthly benefits, but continued to earn interest. If my DROPTerm participation began after July 1, 2010, my DROPTerm account did not accrue additional monthly benefits and did not accrue interest as provided in s. 121.053(7)(a)1., Florida Statutes.
2. I understand that employment termination is required in order to receive my accumulated DROPTerm and monthly benefits. My monthly FRS benefits are payable the calendar month following my employment termination and will be paid on a prospective basis only as provided in s. 121.053(7)(c), Florida Statutes. I am not eligible for retroactive pension benefits or renewed FRS membership coverage for my employment after my DROPTerm participation ended through the calendar month I terminated my elected employment.
3. I understand that I must remain off all payrolls with FRS-covered employers for six calendar months following my employment termination. Prohibited employment includes but is not limited to full-time, part-time, temporary, other personal services (OPS), substitute teaching, adjunct professor or non-Division approved contractual services. If I fail to meet this requirement, I will void my retirement and forfeit my accumulated DROPTerm benefit, including interest, retroactive to my enrollment date in the DROPTerm.
4. I understand that if I void my DROPTerm benefit, my FRS employer will be responsible for making retroactive retirement contributions and I will be awarded service credit for the time period I was in the DROPTerm. I will be eligible for a service retirement benefit based on my new termination date and the Division's receipt of my Application for Service Retirement (Form FR-11). My service retirement benefit will be based on my creditable service and salary, including such service and salary earned while participating in the DROPTerm. I may not be eligible to participate in DROPTerm in the future.

**MEMBER CERTIFICATION:**

I acknowledge that I will terminate or have terminated employment with my FRS employer on \_\_\_\_\_. I further 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 named member will terminate or has terminated on \_\_\_\_\_ with the Agency, who I am authorized to represent.

Authorized Signature: \_\_\_\_\_ Position Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Agency #: \_\_\_\_\_ Date: \_\_\_\_\_