



EMPLOYMENT TERMINATION FORM



To receive an Investment Plan distribution, employers must submit a member's termination date to the Division of Retirement either on the monthly retirement report or via FRS Online. On an exception only basis, this form can be used to verify a member's termination date. Do **not** submit this form any earlier than the 15th of the month prior to a member's distribution eligibility date, and if **any** of the following apply:

- You can submit the termination date timely on the monthly retirement report or via FRS Online;
- Member has not terminated ALL employment (including temporary, part-time, adjunct, or OPS position regardless of FRS eligibility) with all Florida Retirement System (FRS) participating employers; or
- Member is continuing employment with your agency in any capacity (including temporary employment, OPS, etc.).

Under Florida law, a member may not receive benefits under the Investment Plan unless the member has been terminated from **all** employment with all FRS employers for three (3) calendar months not including the month of distribution. The only exception to this 3 calendar month period is if the member meets the Investment Plan's normal retirement requirements, in which case, the member may be eligible to receive a one-time distribution of up to 10% of their account balance after being off all FRS-covered payrolls for 1 complete calendar month and the remaining balance after a total of 3 calendar months.

If you have any questions, please call the Employer Assistance Line, toll-free at 1-866-377-2121, Option 3.

CERTIFICATION OF TERMINATION BY FRS AGENCY

The following information below MUST be completed and signed by the authorized employer signatory. If the person signing this form is not the authorized employer signatory, the termination date will not be processed.

By completing this form, I hereby certify that the below member terminated employment with this agency on:

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Date of Termination
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Last Four SSN:	Last Name	First Name	MI	Birth Date

Please Print: Name of authorized employer signatory

Signature (Authorized Employer Signatory)

Date

(_____)_____
Telephone Number

Employing Agency Name

Employing Agency Code Number

Mail to:
FRS Investment Plan Administrator OR
PO Box 785027
Orlando, FL 32878-5027

FAX to:
1-888-310-5559
Attn: FRS Investment Plan Administrator
DO NOT MAIL HARD COPY IF FAXING

Note: This form will NOT initiate a distribution. Any FRS employer who hires any retired FRS member (Pension Plan or Investment Plan) in violation of the reemployment after retirement provisions will be held jointly and severally liable for reimbursement of any FRS benefits paid.