

**Florida Retirement System Pension Plan
Service Retirement Agreement**



PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Name: _____ SSN: _____

I, _____, hereby elect to receive service retirement benefits while I pursue my claim for disability through the appeal process of the State Retirement Commission.

I understand and acknowledge that if my disability retirement claim is ultimately approved, my service retirement will be converted to disability retirement; however, the retirement option selected cannot be changed.

I further understand and acknowledge that if the State Retirement Commission or the Court does not approve my disability retirement claim, my decision to receive service retirement cannot be revoked, and my retirement option selected cannot be changed.

Applicant Phone No. _____

Applicant Address: _____

APPLICANT MUST SIGN AND DATE IN THE PRESENCE OF A NOTARY PUBLIC.

Member Signature: (sign in the presence of a Notary) _____

Notary: State of Florida, County of _____. The above named person who has sworn to and subscribed before me this ____ day of _____ 20 ____ and is personally known _____ or has produced _____ as identification.

Signature of Notary Public

Print, Type or Stamp Commissioned Name of Notary Public