

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

PO Box 9000  
Tallahassee FL 32315-9000  
(850) 488-2968  
Toll Free: 1-877-738-3725



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.**

Applicant Signature (Sign in presence of Notary Public): \_\_\_\_\_

**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