

**RIVIERA BEACH MUNICIPAL FIREFIGHTERS PENSION  
TRUST FUND**

**Designation Of Beneficiary**

- DROP PLAN  
 PENSION FUND       SHARE PLAN

\_\_\_\_\_  
(Participant Name)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Date Of Birth)

**(Please Print Or Type)**

***Primary Beneficiary(ies)***

I hereby designate the following person(s) as my principal beneficiary(ies) entitled to receive any benefit due in the event of my death. Pay my share of the Fund in equal shares (or percentages indicated below) to the following designated person(s). If percentages shown below for surviving beneficiaries do not total 100%, I direct the Pension Fund to pro-rate the benefits in proportion to the percentages shown.

\_\_\_\_\_  
(Name) (Percentage)

\_\_\_\_\_  
(Name) (Percentage)

\_\_\_\_\_  
(Social Security Number) (Relationship)

\_\_\_\_\_  
(Social Security Number) (Relationship)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(Date Of Birth) (Phone Number)

\_\_\_\_\_  
(Date Of Birth) (Phone Number)

\_\_\_\_\_  
(Name) (Percentage)

\_\_\_\_\_  
(Name) (Percentage)

\_\_\_\_\_  
(Social Security Number) (Relationship)

\_\_\_\_\_  
(Social Security Number) (Relationship)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(Date Of Birth) (Phone Number)

\_\_\_\_\_  
(Date Of Birth) (Phone Number)

***Contingent Beneficiary***

If none of the above-named beneficiary(ies) survive me, I designate the following person(s) as my contingent beneficiary(ies) entitled to receive any benefit due in the event of my death. Pay my share of the Fund in equal shares (or percentages indicated below) to the following designated person(s):

\_\_\_\_\_  
(Name) (Percentage)

\_\_\_\_\_  
(Name) (Percentage)

\_\_\_\_\_  
(Social Security Number) (Relationship)

\_\_\_\_\_  
(Social Security Number) (Relationship)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(Date Of Birth) (Phone Number)

\_\_\_\_\_  
(Date Of Birth) (Phone Number)

**Contingent Beneficiary Continued**

\_\_\_\_\_  
(Name) (Percentage)  
\_\_\_\_\_  
(Social Security Number) (Relationship)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)  
\_\_\_\_\_  
(Date Of Birth) (Phone Number)

\_\_\_\_\_  
(Name) (Percentage)  
\_\_\_\_\_  
(Social Security Number) (Relationship)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)  
\_\_\_\_\_  
(Date Of Birth) (Phone Number)

The above designation of beneficiaries revokes any and all prior designation of beneficiaries for the accounts indicated. I understand that the beneficiary I select may affect the amount of benefits to be paid to me.

\_\_\_\_\_  
Employee's Signature (Requires Notarization Below) Date

STATE OF

COUNTY OF

BEFORE ME, the undersigned authority, personally appeared \_\_\_\_\_,  
who is personally known to me or has produced \_\_\_\_\_ as identification and  
who did take an oath and, after being duly cautioned and sworn, deposes and says that he/ she has signed  
the foregoing document for the reasons therein contained.

SWORN TO AND SUBSCRIBED before me this the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Florida  
At Large

My Commission Expires:

My Commission Number Is: