CITY OF MIAMI BEACH
MIAMI BEACH EMPLOYEES' RETIREMENT PLAN
APPLICATION FOR RETIREMENT OR PENSION ALLOWANCE

Date: _____

I hereby apply for monthly payments from the Miami Beach Employees Retirement System as provided by Section **5.01** of Ordinance **2006-3504** under the following provision:

☐ Ordinary Service Retirement   ☐ Dependent Beneficiary of Retiree
☐ Joint Service Retirement __ Continuation   ☐ Ordinary Disability Retirement
☐ Dependent Beneficiary of Employee   ☐ Service Disability Retirement
☐ Partial lump sum distribution

My date of birth is (proof of birth date required): _____

I have completed _____ years of creditable service as a member of the pension system.

I request that my benefits be computed to commence on : _____ _____

My spouse's date of birth is (proof of birth date required on joint retirement): _____

My registered domestic partner's date of birth is (proof of birth date required on joint retirement): _____

The following questions are to be answered by persons claiming beneficiary benefits:

Name of employee or retiree upon whom you were dependent: _____

Date of death (death certificate required): _____

Relationship: _____

The following questions are to be answered by persons claiming disability benefits:

What disability do you claim? _____

How does your claimed disability affect your work? _____

(You are required to submit the results of a complete medical examination by your own physician.)

Witnessed by _____   Signature: _____

                                              _____
                                              Street Address

Witnessed by _____   _____
                                              City, State & Zip Code

☐   _____
                                              Telephone Number

                                              _____
                                              Social Security Number

                                              _____
                                              POSITION TITLE

                                              _____
                                              DEPT.