

**CITY OF ORLANDO
FIRE FIGHTERS' SHARE PROGRAM
DESIGNATION OF BENEFICIARY FORM**

This form is only for those firefighters who were employed as a firefighter at any time during the period of January 1, 1998 – June 30, 2009, who separated from employment prior to July 1, 2009, who may in the future be authorized to participate in the initial allocation of additional state premium tax revenues collected during calendar years 1998 - 2008.

If I, _____ (print name), should die before I or the third party administrator (Nationwide Retirement Solutions, Inc.) of the Orlando Firefighters' Share Program, receives my SHARE PROGRAM benefits, I designate the following person(s) or trust(s) to be my beneficiary(ies) of those SHARE PROGRAM benefits that I may be authorized to receive.

1. Primary Beneficiary Name: _____ DOB: _____ %
Relationship: _____ Social Security No.: _____
Beneficiary's Address: _____
City: _____ State: _____ Zip Code: _____

2. Primary Beneficiary Name: _____ DOB: _____ %
Relationship: _____ Social Security No.: _____
Beneficiary's Address: _____
City: _____ State: _____ Zip Code: _____

3. Primary Beneficiary Name: _____ DOB: _____ %
Relationship: _____ Social Security No.: _____
Beneficiary's Address: _____
City: _____ State: _____ Zip Code: _____

4. Primary Beneficiary Name: _____ DOB: _____ %
Relationship: _____ Social Security No.: _____
Beneficiary's Address: _____
City: _____ State: _____ Zip Code: _____

NOTE: TOTAL OF PRIMARY BENEFICIARY(IES) MUST EQUAL 100% %

If a beneficiary spot is not used, please draw a line through it, write 0% in the blank, and initial it.

In the event that any of the foregoing named primary beneficiaries predecease me, then the portion payable to that person(s) or trust(s) shall be payable as designated herein. [If you designate more than one (1) primary beneficiary, you may designate that the surviving primary beneficiary(ies) shall receive the predeceased primary beneficiary(ies) share(s) or you may designate the contingent beneficiary(ies) to receive the predeceased primary beneficiary(ies) share(s).]

1. Contingent Beneficiary Name: _____ DOB: _____ %
Relationship: _____ Social Security No.: _____
Beneficiary's Address: _____
City: _____ State: _____ Zip Code: _____

(over)

2. Contingent Beneficiary Name: _____ DOB: _____ %
 Relationship: _____ Social Security No.: _____
 Beneficiary's Address: _____
 City: _____ State: _____ Zip Code: _____
3. Contingent Beneficiary Name: _____ DOB: _____ %
 Relationship: _____ Social Security No.: _____
 Beneficiary's Address: _____
 City: _____ State: _____ Zip Code: _____
4. Contingent Beneficiary Name: _____ DOB: _____ %
 Relationship: _____ Social Security No.: _____
 Beneficiary's Address: _____
 City: _____ State: _____ Zip Code: _____

NOTE: TOTAL OF CONTINGENT BENEFICIARY(IES) MUST EQUAL 100% %

If a beneficiary spot is not used, please draw a line through it, write 0% in the blank, and initial it.

You may add additional primary beneficiaries, but the sum of the percentages for all primary beneficiaries must equal 100%. You may also add additional contingent beneficiaries, but the sum of the percentages for all contingent beneficiaries must equal 100%. Unless otherwise directed, contingent beneficiaries will receive only that percentage designated for the primary beneficiaries that happen to predecease them.

This designation will continue to be effective unless I submit a new **Designation of Beneficiary Form** adopted by the Trustees.

I understand that if any designated beneficiary predeceases me it would be best if I complete and file with Employee Benefits a new **Designation of Beneficiary Form** for my accumulated SHARE PROGRAM benefit.

Signature

Date

Social Security Number

Employee Number

STATE OF FLORIDA
COUNTY OF ORANGE

The foregoing instrument was acknowledged before me this ____ day of _____, 20____
 by _____, who is personally known to me or
 who has produced _____ as identification.

NOTARY PUBLIC