SUN COAST POLICE BENEVOLENT ASSOCIATION

14141 46th Street North, Suite #1205 Clearwater, FL 33762
Phone: 727-532-1722 Fax: 727-530-4816

$2,500.00 DEATH BENEFIT BENEFICIARY FORM

PLEASE READ AND COMPLETE THIS FORM WHETHER OR NOT YOU ELECT OR DECLINE THIS $2,500.00 DEATH BENEFIT. THIS FORM AND ANY ADDITIONAL FORMS MUST BE NOTARIZED. TO DECLINE THIS BENEFIT, WRITE *"DECLINE"* ACROSS THIS PAGE AND HAVE IT NOTARIZED. THE DATE OF THIS FORM SHALL RENDER ANY PREDATED FORM(S) INVALID. FAILURE TO EXECUTE THIS FORM CORRECTLY WILL INVALIDATE THIS BENEFIT UNTIL COMPLETED CORRECTLY. YOU WILL NOT BE CONSIDERED A PBA MEMBER IF THIS FORM IS NOT RETURNED.

I, _____, acknowledge that one of the benefits to a PBA member is that in the event of my death $2,500.00 will be paid to the person(s) I have listed as my beneficiary. Said payment will only be distributed at the time of my death if I am current with dues and in good standing with the PBA. This benefit is payable regardless of whether or not I am acting in the performance of my duties, off duty, on medical, sick or vacation leave or retired at the time of my death. However, this benefit is void if cause of death is determined to be by intentional self-inflicted injury or suicide. It is my obligation to assure this form is received by the PBA and current. If no designee is listed, a designated person does not survive me or this form is invalid for any reason, this benefit shall be forfeited and the benefit remains with the PBA. **This benefit is only valid for 90 days after my death and it is my obligation to notify my listed beneficiaries of its existence.** In the event there are multiple beneficiaries listed and at time benefit becomes due, if one or more beneficiaries are not entitled to their percentage (i.e. do not survive me, unattainable location, etc.) then the remaining beneficiary will only receive the percentage of the benefit you listed for him/her.

I hereby designate the following person(s) as a beneficiary of my benefit:

Primary Beneficiary: _____ % to be paid.

Name: _____

DOB or SS #_____

Relation: _____

Address: _____

City, State, Zip: _____

Alternate Beneficiary: _____ % to be paid.

Name: _____

DOB or SS #_____

Relation: _____

Address: _____

City, State, Zip: _____

I understand that this designation is valid unless changed or cancelled by me **in writing**. The PBA shall have no obligation or responsibility to investigate the relationship between myself and the designated beneficiary before making payment and shall make such payment regardless of the relationship existing between myself and such designated beneficiary. In the event that I have designated my spouse, the benefit shall be paid as indicated even if I subsequently become divorced, unless I change the designee.

I understand that prior to this benefit becoming due and payable, the PBA reserves the right to amend, change, modify or cancel this benefit at any time and without notice. Furthermore, it is at the sole discretion of the PBA to enforce this benefit at the time of my death, thus my estate and listed beneficiaries shall hold harmless the PBA for any decision the PBA renders in accord with this form and in good faith.

My signature below establishes that I have read, understood and agree with the terms and conditions of this benefit.

_____
MEMBER'S SIGNATURE

State of Florida
County of Pinellas

I hereby certify that the foregoing instrument was acknowledged freely and voluntarily before me this _____ day of_____, 20___, and this person is: Personally known _____ or produced identification _____ Type of identification produced_____ .

Notary Public: _____

Commission expiration: _____

***Is there an additional beneficiary form attached: _____ YES ____NO**

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ADDITIONAL BENEFICIARIES FORM

Additional Beneficiary #___: _____ % to be paid.

Name: ____________________________________

Social Security # ____________________________

Relation: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

Additional Beneficiary #___: _____ % to be paid.

Name: ____________________________________

Social Security # ____________________________

Relation: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

Additional Beneficiary #___: _____ % to be paid.

Name: ____________________________________

Social Security # ____________________________

Relation: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

Additional Beneficiary #___: _____ % to be paid.

Name: ____________________________________

Social Security # ____________________________

Relation: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

Additional Beneficiary #___: _____ % to be paid.

Name: ____________________________________

Social Security # ____________________________

Relation: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

Additional Beneficiary #___: _____ % to be paid.

Name: ____________________________________

Social Security # ____________________________

Relation: ___________________________________

Address: ___________________________________

City, State, Zip: _____________________________

____
MEMBER'S SIGNATURE

State of Florida
County of Pinellas

I hereby certify that the foregoing instrument was acknowledged freely and voluntarily before me this _____ day of__________, 20___, and this person is: Personally known ________ or produced identification ________ Type of identification produced_____________________________ .

Notary Public: ________________________________

Commission expiration: ________________________

***Is there an additional beneficiary form attached: _____ YES ____NO** **Ver. 4.19.2013**