Arkansas Fire and Police Pension Review Board
Attachment 2

ARKANSAS FIRE AND POLICE LOCAL PLANS
DEFERRED RETIREMENT OPTION PLAN (DROP)

MEMBER ELECTION FORM

I hereby elect the DROP as my retirement benefit option from the pension plan in place of the normal retirement benefit. I understand that in electing the DROP I have agreed to the following statements:

1. * The amount of the DROP payments will be $____per month. This amount includes all service and age 60 bonuses that I have earned to this date. This amount is the same as if I retired today.

2. * I understand that the monthly benefit that I will receive at the end of the DROP period is the exact same amount stated in item 1, regardless of any pay raises I receive or extra years of accrued service.

3. I understand that at the end of the DROP period I will have the option to receive the DROP account as a lump sum or convert the DROP account to a monthly annuity amount.

4. I understand that the DROP account will remain in the pension fund until I leave the department. I do not have the ability to withdraw from the DROP account until I terminate covered employment.

5. I have elected to begin the DROP on _____. The DROP will end at the earlier of when I terminate covered employment or_____ (5 years from above date, or 10 years, for eligible pension funds).

6. I understand that neither the pension fund nor the department has given any tax advice concerning the way the DROP account is taxed. I have or will consult my own tax advisor for this information.

* Two exceptions to these rules: Age 60 bonuses (for members with over 25 years of service at the time of enrollment in DROP) begin at age 60 whether still on DROP or not; raises given to retirees that are also given to DROP participants.

_____ Date _____
Member
Signature

_____
Plan Representative

Date

_____

Attachment 2 (Continued)

ARKANSAS FIRE AND POLICE LOCAL PLANS
DEFERRED RETIREMENT OPTION PLAN (DROP)
MEMBER ELECTION FORM

DESIGNATION OF BENEFICIARY

I hereby designate the following beneficiary to receive any benefits from my DROP account if I die prior to my termination of covered employment:

_____ Date _____

Signature of Member

Please select one of the following:

_____ I certify that to the best of my knowledge, the above named Member is single or that his spouse cannot be located.

_____ Date _____

Signature of Plan Representative
Or Notary

_____ I certify that I have agreed with my spouse on the selection of the above beneficiary or beneficiaries. I understand that if I am not the named beneficiary, I will not be entitled to benefits under the plan.

_____ Date _____

Signature of
Spouse

I certify that I have witnessed the spouse's signature above.

_____ Date _____

Signature of Plan Representative
Or Notary