FPPA Membership Form

Statewide Defined Benefit Plan

Statewide Hybrid Plan - Defined Benefit Component

Fire and Police Pension Association
5290 DTC Parkway
Greenwood Village
Colorado 80111
(303) **770-3772**
toll free (800) 332-3772
www.FPPAco.org

INSTRUCTIONS - When filling out this form, please type or print legibly in ink. When the form is complete, return it to FPPA at the address above. You may want to keep a copy for your records. Check all boxes that apply.

☐ NEW EMPLOYEE - Complete the *entire* form.
New employees (except Civilian or Clerical Staff) **must also complete the *Statewide Standard Health History Form*.**

Please Note: If you are retired from the Statewide Defined Benefit Plan, or the Statewide Hybrid Plan please contact FPPA or refer to Section 311 of the FPPA Rules to ensure that you are completing the proper Membership Form and enrolling in the appropriate pension plan.

☐ CHANGES TO GENERAL INFORMATION - Complete Part A below.

☐ CHANGES TO BENEFICIARY DESIGNATION - Complete Part A and Part C below.

PART A - GENERAL INFORMATION

Employer _____ ☐ *Police* ☐ *Fire*
Name of your employer - city, town or district

_____ _____ _____ _____ - _____ - _____
Last Name *First Name* *Middle Initial* *Social Security #*

_____ *Male* ☐ *Female* ☐ *Marital Status: Single* ☐ *Married* ☐
Mailing Address

_____ _____ _____ *Date of Birth* _____ /_____ /_____
City *State* *Zip* *Month* *Day* *Year*

(_____) _____ - _____ (_____) _____ - _____ _____
(Area Code) Home Phone Number *(Area Code) Work Phone Number* *Email address*

_____ *Date of Birth* _____ /_____ /_____
Spouse's Name (Check which applies) ☐ *Marriage* ☐ *Civil Union* *Month* *Day* *Year*

PART B - EMPLOYMENT INFORMATION

Hire Date _____ /_____ /_____ *Gross Salary Per Month $* _____
Month *Day* *Year*

Employed: *Full Time*..... ☐ *Civilian/Clerical Full Time*..... ☐

Rank/Position _____ *Average Number of Hours Per Week* _____

continued inside

PART C - BENEFICIARY DESIGNATION

This section may be used only for benefits payable under the Statewide Defined Benefit (SWDB) Plan or the Statewide Hybrid (SWH) Plan-Defined Benefit Component. This beneficiary may apply to benefits payable upon death prior to retirement eligibility, or in some cases after retirement eligibility, as provided in the Colorado Revised Statutes and the FPPA Rules and Regulations.

In the future, you may revoke this form and designate a different beneficiary by completing and delivering to FPPA another Membership Form with the Beneficiary Designation section completed.

Designated Beneficiary of your SWDB or SWH Plan: If you die while an active member and leave no surviving spouse or dependent children who are eligible for benefits under the Statewide Death and Disability Plan, a benefit under the SWDB or SWH Plan may be calculated for your designated beneficiary. If no beneficiary is designated or your named beneficiary(ies) is deceased, a lump sum payment may be made to your estate. To change beneficiaries for FPPA accounts that are serviced by Fidelity Investments (Statewide Money Purchase, 457 Deferred Compensation, DROP, Self-directed SRA, or the Statewide Hybrid Plan–Money Purchase Component), please contact Fidelity at 1-800-343-0860.

PLEASE NOTE: **If this form is being submitted and indicates a change in Part C-Beneficiary Designation, the Member hereby elects to revoke any previous designated beneficiary and elects to make a designation as indicated. This means that if you wish to retain any beneficiary that you named previously, you must reenter this information in the appropriate section.**

Only ONE person can be named as a PRIMARY BENEFICIARY. Only ONE person can be named as a CONTINGENT BENEFICIARY. If you want multiple beneficiaries to receive a one-time refund, please enter them in the section titled REFUND ONLY BENEFICIARIES OR ESTATE OR TRUST on the next page.

PRIMARY BENEFICIARY

☐ No Designated **Primary Beneficiary** is elected and any previously elected Designated Beneficiary is hereby revoked.
- or -
☐ The following is named as my **Primary Beneficiary**:

_____ *Male* ☐ *Female* ☐ _____
Beneficiary's Full Legal Name *Relationship*

_____ XXX-XX- ☐☐☐☐
Address *Social Security Number (last 4 digits)*

_____ _____ _____ *Date of Birth:* ____ /____ /____
City *State* *Zip* *Month* *Day* *Year*

(_____) _____ - _____ (_____) _____ - _____ *Email address:* _____
(Area Code) Home Phone Number *(Area Code) Work Phone Number*

CONTINGENT BENEFICIARY (Person to receive payment if your primary beneficiary is deceased.)

☐ No Designated **Contingent Beneficiary** is elected and any previously elected Designated Beneficiary is hereby revoked.
- or -
☐ The following is named as my **Contingent Beneficiary**:

_____ *Male* ☐ *Female* ☐ _____
Beneficiary's Full Legal Name *Relationship*

_____ XXX-XX- ☐☐☐☐
Address *Social Security Number (last 4 digits)*

_____ _____ _____ *Date of Birth:* ____ /____ /____
City *State* *Zip* *Month* *Day* *Year*

(_____) _____ - _____ (_____) _____ - _____ *Email address:* _____
(Area Code) Home Phone Number *(Area Code) Work Phone Number*

■ **REFUND ONLY BENEFICIARIES OR ESTATE OR TRUST** - Mark only ONE box below. (This section applies only to a one-time refund of remaining member contributions not paid out in monthly pension benefits and only when there is no primary or contingent beneficiary payable. No monthly pension benefit would be paid to the beneficiaries listed below.) Any previously elected Multiple Beneficiaries, Estate or Trust is revoked.

☐ No Designated **Refund Only Beneficiaries OR Estate OR Trust** are elected

☐ I elect my **Estate** to receive a refund of remaining member contributions, if any.

☐ The following **Trust** is elected to receive a refund of remaining member contributions, if any.

_____
Name of Trust

☐ The following are named as **Refund Only Beneficiaries** to receive a refund of remaining member contributions, if any. If you have more than three, attach a page and check here. _____ I have attached a page.

_____
Name

_____ ___ ___ ___ ___
Relationship *Last 4 #'s of SS*

_____ _____
Date of Birth *Phone Number*

_____ **Percent of Assets** _____ **%**
Email Address

_____
Name

_____ ___ ___ ___ ___
Relationship *Last 4 #'s of SS*

_____ _____
Date of Birth *Phone Number*

_____ **Percent of Assets** _____ **%**
Email Address

_____
Name

_____ ___ ___ ___ ___
Relationship *Last 4 #'s of SS*

_____ _____
Date of Birth *Phone Number*

_____ **Percent of Assets** _____ **%**
Email Address

All Percentage of Assets listed above must equal = 100%.

- I understand that this beneficiary designation does not apply if benefits are payable under the Statewide Death and Disability Plan.
- I am aware that the beneficiary information included in this form becomes effective when a fully completed form is received by FPPA and will remain in effect until I deliver another completed and signed Beneficiary Designation Form to FPPA at a later date.
- I understand that I may designate a beneficiary for my assets accumulated under the SWDB Plan or the SWH Plan-Defined Benefit Component and that if I choose to not designate a beneficiary, my benefit will be paid based on the provisions of the Plan.
- I am aware that the beneficiary information provided herein shall apply to the SWDB Plan or the SWH Plan-Defined Benefit Component and shall replace all previous designation(s) I have made to my account under this Plan.

✗ _____ _____
Your Signature *Date*