

FPPA Membership Form

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

Statewide Defined Benefit Plan

Statewide Hybrid Plan - Defined Benefit Component

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 one box below.

- NEW MEMBER** - Complete the *entire* form.
New employees (except Civilian Clerical Staff) **must also complete the Statewide Standard Health History Form.**
- CHANGES ONLY** - Complete Part A below and any other information you wish to change.

REMINDER - You and a witness must sign and date the back of this form for it to become effective.

PART A - GENERAL INFORMATION

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

Address _____ Male Female Marital Status: Single Married

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

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

Spouse's Name _____ Spouse's Date of Birth _____ / _____ / _____
Month Day Year

PART B - HIRING EMPLOYER

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

Hire Date _____ / _____ / _____ Gross Salary Per Month \$ _____ Employed: Full Time.....
Month Day Year Civilian/Clerical Full Time.....

Rank/Position _____ Average Number of Hours Per Week _____

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.

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.

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

continued on back

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 and contingent beneficiary are deceased, a lump sum payment may be made to your estate. If you are making changes to your beneficiaries and you leave either beneficiary section blank, the previous beneficiary in that area will remain. To change beneficiaries for FPPA accounts that are serviced by Fidelity Investments (Statewide Money Purchase, 457 Deferred Compensation, DROP, Affiliated Money Purchase, or the Statewide Hybrid Plan–Money Purchase Component), please contact Fidelity at 1-800-343-0860.

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

Address

Social Security #

City

State

Zip

Date of Birth: ____/____/____
Month Day Year

(____)____ - ____ (____)____ - ____
(Area Code) Home Phone Number (Area Code) Work Phone Number

Email address: _____

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

Address

Social Security #

City

State

Zip

Date of Birth: ____/____/____
Month Day Year

(____)____ - ____ (____)____ - ____
(Area Code) Home Phone Number (Area Code) Work Phone Number

Email address: _____

- 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 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 beneficiary will be made 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.

X _____
Your Signature Date

X _____
Witness Signature Date
(someone other than your spouse or beneficiary)

Witness (Please print name)