# City of West Palm Beach Police Pension Fund
# 2100 N. Florida Mango Road
# West Palm Beach, Florida 33409

## AFFIDAVIT - CONFIRMATION OF RECEIPT OF RETIREMENT BENEFITS 2022

I, the undersigned affiant hereby confirms, that I am currently receiving a monthly retirement benefit from the City of West Palm Beach Police Pension Fund and that my entitlement to receive such benefit has not changed since benefits began. (Note: Disability Recipients UNDER AGE 50 must complete this form and continue to page two).

_____ _____
*(Retiree or Beneficiary, **MUST** Print Name)* *(Retiree or Beneficiary Signature / Date)*

_____
*(Current Home Address, City, State, Zip Code)* (____) Please check here if new address

_____ _____
*(Area Code & Telephone Number)* *(Your E-Mail Address)*

**PLEASE LIST CLOSEST RELATIVE NOT LIVING WITH YOU**

_____ _____
(*Name, Please Print*) (*Relationship*)

_____
*(Current Home Address, City, State, Zip Code)*

_____
*(Area Code & Telephone Number)*

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STATE OF_____ COUNTY OF _____

The foregoing instrument was acknowledged before me this _____by
(*Date*)
_____, who is personally known to me or who has produced
*(Name of Person Acknowledging)*

_____ as identification and who did (did not) take an oath.
*(Type of Identification Produced)*

_____
*(Signature of Notary Public)*

_____ Notary Public, Commission No. _____
*(Name of Notary typed, printed or stamped)*

**THIS FORM MUST BE SIGNED PERSONALLY BY THE RETIREE, (OR THE BENEFICIARY, IF THE RETIREE IS DECEASED). IF NOT SIGNED BY THE RETIREE OR THE BENEFICIARY. A LETTER OF EXPLANATION FOR SUCH FAILURE MUST BE RETURNED WITH THIS FORM OR YOUR PAYMENT MAY BE INTERRUPTED.**

# 2022 DISABILITY RETIREE MEDICAL REVIEW

**This form applies to disability recipients <u>who are under age 50</u> only**

In accordance with the pension plan at §16(16)(e), I, _____, hereby certify that I continue to be disabled from performing the functions of a Police Officer. In support of this certification, attached are medical records, dated within six months of today, demonstrating the continuing nature of my disability. Failure to substantiate your continuing disabling medical condition can result in the suspension and/or termination of your pension benefit.

I hereby waive my right of confidentiality of my medical records and other medical evidence in order that my medical review may be properly processed. I understand that in so doing, such records will be discussed during one or more public meetings and will become public record. I understand that the Board(s) will rely upon this waiver and that I will not be able to withdraw same at a later date.

I understand that if this report is false, incorrect or incomplete my disability retirement benefits may be discontinued. Additionally, pursuant to §185.185 Fla. Stat., if my report is false, I may be subject to a first-degree misdemeanor.

_____

*(Disability Recipient Signature / Date)*

STATE OF_____ COUNTY OF _____

The foregoing instrument was acknowledged before me this _____by
*(Date)*

_____, who is personally known to me or who has produced
*(Name of Person Acknowledging)*

_____ as identification and who did (did not) take an oath.
*(Type of Identification Produced)*

_____
*(Signature of Notary Public)*

_____ Notary Public, Commission No. _____
*(Name of Notary typed, printed or stamped)*

**<u>PLEASE NOTE: Upon reaching age 55, you may elect to convert to a normal retirement and receive credit for years of service while on a disability pension. It is up to YOU to request the conversion.</u>**