SUN COAST POLICE BENEVOLENT ASSOCIATION, INC.

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

$2,500.00 DEATH BENEFIT FORM

PLEASE READ AND COMPLETE THIS FORM WHETHER OR NOT YOU ELECT TO PARTICIPATE IN THIS $2,500.00 DEATH BENEFIT. THIS FORM MUST BE NOTARIZED. TO DECLINE THIS BENEFIT, WRITE *"DECLINE"* ACROSS THIS PAGE AND HAVE IT NOTARIZED. THE DATE OF THIS FORM SHALL VOID ANY PREDATED FORM(S). FAILURE TO EXECUTE THIS FORM CORRECTLY WILL INVALIDATE THIS BENEFIT.

I, _____, acknowledge that one of the benefits to me as a Sun Coast PBA member is that in the event of my death $2,500.00 will be paid to the person(s) I have listed below as my beneficiary/beneficiaries. This payment will only be distributed at the time of my death if I am current with dues and in good standing with the Sun Coast PBA. This benefit is payable upon my death regardless of whether I am acting in the performance of my duties, off duty, on medical, sick or vacation leave or retired. It is my obligation to make sure that this form is received by the Sun Coast PBA and that all data on this form is current and reflects my wishes. If no beneficiary is listed, if my beneficiaries do not survive me, or if this form is invalid for any other reason as determined in the sole discretion of the Sun Coast PBA, this benefit shall be forfeited by me, my estate, and my beneficiaries. **It is my obligation to notify my beneficiaries of the existence of this benefit. I understand that my beneficiaries must claim this benefit by contacting the Sun Coast PBA within 90 days of the date of my death.**

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: _____

Phone: _____

Alternate Beneficiary: _____ % to be paid.

Name: _____

DOB or SS #_____

Relation: _____

Address: _____

City, State, Zip: _____

Phone: _____

I understand that this designation is valid unless changed or cancelled by me **in writing**. The Sun Coast PBA shall have no obligation or responsibility to investigate the relationship between me and my beneficiary/beneficiaries before making payment. 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 my beneficiary.

I understand that prior to this benefit becoming due and payable, the Sun Coast 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 Sun Coast PBA to enforce this benefit at the time of my death, thus my estate and listed beneficiaries shall hold harmless the Sun Coast PBA for any decision it renders.

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

_____

MEMBER'S SIGNATURE

State of Florida
County of _____

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: ____

DOB or SS #___________________________________

Relation: ______________________________________

Address: _______________________________________

City, State, Zip: _________________________________

Phone: ____

Additional Beneficiary #___: _____ % to be paid.

Name: ____

DOB or SS #___________________________________

Relation: ______________________________________

Address: _______________________________________

City, State, Zip: _________________________________

Phone: ____

Additional Beneficiary #___: _____ % to be paid.

Name: ____

DOB or SS #___________________________________

Relation: ______________________________________

Address: _______________________________________

City, State, Zip: _________________________________

Phone: ____

Additional Beneficiary #___: _____ % to be paid.

Name: ____

DOB or SS #___________________________________

Relation: ______________________________________

Address: _______________________________________

City, State, Zip: _________________________________

Phone: ____

Additional Beneficiary #___: _____ % to be paid.

Name: ____

DOB or SS #___________________________________

Relation: ______________________________________

Address: _______________________________________

City, State, Zip: _________________________________

Phone: ____

Additional Beneficiary #___: _____ % to be paid.

Name: ____

DOB or SS #___________________________________

Relation: ______________________________________

Address: _______________________________________

City, State, Zip: _________________________________

Phone: ____

____

MEMBER'S SIGNATURE

State of Florida
County of ____________

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. 5.20.20