



CITY OF MARGATE EMPLOYEE BENEFIT TRUST FUND

c/o Margate City Clerk's Office 5790 Margate Boulevard Margate, FL 33063 (954) 972-6454 cityclerk@margatefl.com

APPLICATION FOR BENEFITS

IMPORTANT: THIS FORM MUST BE SUBMITTED BY **NOVEMBER 15 TO RECEIVE BENEFITS THE FOLLOWING JANUARY.**

Yes No **You must provide the following 2 items when applying for your benefit:**

		1. Have you provided proof that you are receiving an FRS Benefit such as a certificate or pay stub?
		2. Have you provided proof of an insurance premium such as an invoice from your medical provider or pay stub?
		3. Is your insurance provided through the City of Margate? If yes, you do not have to provide number 2.

Member Information

Name (First, Middle, Last)			
Address		Date of Birth (MM/DD/YYYY)	
City	State	Zip Code	
Spouse Name	Telephone Number	Other Telephone Number	

Employment Information

Date of Hire	Date of Separation	Department Worked
FRS Classification (Check one): <input type="checkbox"/> ESCOC <input type="checkbox"/> Regular <input type="checkbox"/> Special Risk <input type="checkbox"/> Senior Management		

Continuing Health Insurance Information

Health Insurance Provider	Group Number	Policy Number
Address		
City	State	Zip Code
Telephone Number	Annual Premium	

Designation of Beneficiary

Name of beneficiary		
Address		
City	State	Zip Code
Relationship	Telephone Number	Other Telephone Number

(Print Full Name) (Signature of Affiant) (Date)

STATE OF _____ COUNTY OF _____

The foregoing instrument was acknowledged before me **by means of physical presence or online notarization**

this _____ day of _____, 20_____

By _____ Notary Signature _____
(Name of Person Making Statement)

My commission expires: _____ Personally Known: or ID Type: _____

(seal)