CITY OF MARGATE EMPLOYEE BENEFIT TRUST FUND

c/o Anchor Benefit Consulting - P.O. Box 945260, Maitland, FL 32794 - (800) 845-7629

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 effective upon termination such as a certificate or pay stub?
		2. Have you provided proof of an insurance premium such as an invoice from your insurance 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): ☐ ESCOC ☐ Regular ☐ Special Risk ☐ 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)