

**FLORIDA RETIREMENT SYSTEM**  
**State University System Optional Retirement Program(SUSORP)**  
**Employee Termination Form - Supplemental Statement for Distributions**

**NOTE:** This form is not required for transfers of employer contributions between SUSORP-approved providers or for transfer of employee contributions.

**Completed form should be sent to:**      **Division of Retirement – OAP/ORP Section**  
P.O. Box 9000  
Tallahassee, Florida 32315-9000  
**FAX: 850 410 2026**  
Phone 850-413-9381 or Toll-free: 877-378-7677

I understand that I can not begin receiving my employer-funded benefits while I am employed with any Florida Retirement System (FRS) employer. I have terminated or will terminate all employment with FRS employers on (date) \_\_\_\_\_. I will not work for an FRS employer for one full calendar month following my termination date. For example, if I quit on June 6, the earliest that I can receive my benefit is August 1. I understand that my retirement becomes final when I receive the money or it is rolled-over to a non-SUSORP provider company.

I understand that by receiving my benefit under the SUSORP, if I return to work in an FRS-covered position, I will be considered a renewed member (as defined in 121.122 F.S.). I will not be eligible for disability benefits, Special Risk Class membership, or to participate in the DROP program.

The Florida Statutes are available online at <http://www.flsenate.gov>.

**Member Certification:**      (sign in the presence of a Notary)

Name \_\_\_\_\_ SS# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Notary:**

State of \_\_\_\_\_, County of \_\_\_\_\_. The above named person who has sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ and who is personally known \_\_\_\_\_ or produced \_\_\_\_\_ Identification.

\_\_\_\_\_  
Signature of Notary Public. State of \_\_\_\_\_      Print, Type or Stamp Commissioned Name of Notary Public

**Employer Certification:**

This is to certify that the above named member was employed by this agency and will terminate, or has terminated on \_\_\_\_\_.

Authorized Signature: \_\_\_\_\_ Agency Name/Number: \_\_\_\_\_

Agency Phone: \_\_\_\_\_ SUNCOM: \_\_\_\_\_ Date: \_\_\_\_\_

**Division of Retirement Certification:**

By: \_\_\_\_\_ Date: \_\_\_\_\_