



**WEST PALM BEACH POLICE PENSION FUND
OFFICE OF RETIREMENT**

2100 North Florida Mango Road
West Palm Beach, Florida 33409

Phone: 561.471.0802

FAX: 561.471.5027

**PLEASE REFRAIN SENDING BACK THIS DOCUMENT
UNSECURED VIA E-MAIL. OTHER ALTERNATIVES US MAIL,
FAX (NUMBER CITED ABOVE) OR DROP OFF AT THE
OFFICE.**

ALSO USE LAST 4 OF SSN ONLY.

THANK YOU!



**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 2023

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)

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)

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

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 who are under age 50 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)

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.