

Florida Retirement System Pension Plan
Application for Service Retirement and the
Deferred Retirement Option Program (DROP)

PO Box 9000
Tallahassee FL 32315-9000
850 488-6491 Toll Free 888 738-2252

Member Name VICKIE A. DOWNS
Position Title DIRECTOR
Home Phone 239-252-0835
Home Mailing Address 4660 LAKEWOOD BLVD
NAPLES, FL 34112

Member SSN [REDACTED]
Birthdate 11/30/46
Work Phone 239-252-8147
Present FRS Employer(s) COLLIER COUNTY PROPERTY APPRAISER

I have resigned my employment on the date stated below and elect to participate in the DROP in accordance with s. 121.091(13), Florida Statutes (F.S.). My DROP participation cannot exceed a maximum of 60 months from the date I first reach my normal retirement date as determined by the Division of Retirement.

I understand that I must terminate all employment with FRS employers to receive a monthly retirement benefit and my DROP benefit under Chapter 121, F. S., unless I am an elected officer with membership in the EOC. I cannot add service, change options, change my type of retirement or elect the Investment Plan after the DROP begin date. If I fail to terminate my employment in accordance with s. 121.021(39)(b), F.S., on my DROP termination date, my retirement will be null and void and my FRS membership shall be established retroactively to the date I began DROP. Termination requirements for elected officials are different as specified in s 121.091(13)(b)(4), F.S. I have read and understand the DROP Accrual Distribution information provided with this form.

Beneficiary Designation: All previous beneficiary designations are null and void. To designate more than one primary beneficiary, attach a Beneficiary Designation Form, FST-12.

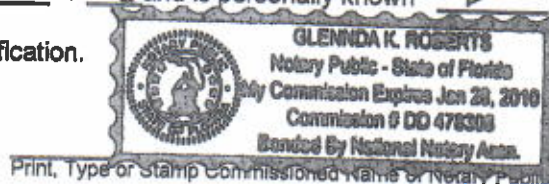
Primary VICKIE A. DOWNS REV TRUST Primary SSN _____
Relationship _____ Primary Birthdate _____
Contingent _____ Contingent SSN _____
Relationship _____ Contingent Birthdate _____

DROP begin date: 10 / 01 / 08 DROP termination and resignation date 9/30/13

Member Signature: (sign in the presence of a Notary) Vickie A. Downs

Notary: State of Florida, County of Collier The above named person has sworn to and
subscribed before me this 26th day of August 20 08 and is personally known ☒
or produced _____ as identification.

Glenn K. Roberts
Signature of Notary Public - State of Florida



Employer Certification: This is to certify that the above named member will be enrolled as a DROP Participant on the date stated and will terminate his or her employment on the date stated.

For educational agencies only: I certify that the member's position of _____ meets the
definition of instructional personnel under Section 1012.01(2), Florida Statutes.

Authorized Personnel Signature: Glenn K. Roberts Agency Number: 21004
Agency Phone: 239 252 8532 Date: 8-26-08

Florida Retirement System Pension Plan
Notice of Election to Participate in the Deferred Retirement Option
Program (DROP) and Resignation of Employment



PO Box 9000
Tallahassee FL 32315-9000
850 488-6491 Toll Free 888 738-2252

Member Name

VICKIE A. DOWNS

Member SSN

Position Title

DIRECTOR

Birth Date

Home Phone

239-289-0835

Work Phone

Home Mailing
Address

4660 LAKEWOOD BLVD
NAPLES, FL 34112

Present FRS
Employer(s)

COLLIER COUNTY PROPERTY
APPRAISER

Resignation From Employment to Participate in the DROP:

I elect to participate in the DROP in accordance with s 121.091(13), Florida Statutes (F.S.), as indicated below, and resign my employment on the date I terminate from the DROP. I understand that the earliest date my participation in the DROP can begin is the first date I reach normal retirement date as determined by law and that my DROP participation cannot exceed a maximum of 60 months from the date I reach my normal retirement date, although I may elect to participate for less than 60 months. Participation in the DROP does not guarantee my employment for the DROP period.

I understand that I must terminate all employment with FRS employers to receive a monthly retirement benefit and my DROP benefit under Chapter 121, F. S., unless I am an elected officer with membership in the EOC. I cannot add service, change options, change my type of retirement or elect the Investment Plan after my DROP begin date. Termination requirements for elected officers are different as specified in s 121.091(13)(b)(4), F. S. I have read and understand the DROP Accrual and Distribution information provided with this form.

DROP begin date:

10 10 11 08

DROP termination and resignation date:

9/30/13

Member Signature: (sign in the presence of a Notary)

Vickie A. Downs

Notary: State of Florida, County of

Collier

The above named person has sworn to and

subscribed before me this 26th day of

August

20 08

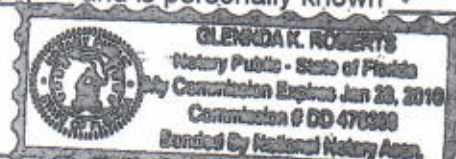
and is personally known ✓

or produced

as identification.

Glenda K. Roberts

Signature of Notary Public - State of Florida



Print, Type or Stamp Commissioned Name of Notary Public

Employer Certification: This is to certify that the above named member will be enrolled as a DROP Participant on the date stated and will terminate his or her employment on the date stated.

For educational agencies only: I certify that the member's position of _____ meets the definition of instructional personnel under Section 1012.01(2) Florida Statutes.

Authorized Personnel Signature:

Glenda K. Roberts

Agency Number:

21004

Agency Phone:

239-252-8532

Date:

8-26-08

Florida Retirement System Pension Plan
Option Selection for FRS Members

P O BOX 9000
TALLAHASSEE FL 32315-9000
850 488-6491 Toll Free 888 738-2252

Member Name Vickie A. Downs Member SSN [REDACTED]

A member must select one of the following retirement options prior to receipt of their first monthly retirement benefit.

I select:

☒ Option 1: A monthly benefit payable for my lifetime. Upon my death the monthly benefit will stop and my beneficiary will receive only a refund of any contributions I have paid which are in excess of the amount I have received in benefits. This option does not provide a continuing benefit to my beneficiary.

☐ Option 2: A reduced monthly benefit payable for my lifetime. If I die within a period of ten years after my retirement date, my designated beneficiary will receive a monthly benefit in the same amount as I was receiving for the balance of the 10-year period. No further benefits are then payable.

THIS SECTION MUST BE COMPLETED IF YOU SELECT OPTION 1 OR 2.

MARRIED: ☒ YES ☐ NO IF YES, YOUR SPOUSE MUST SIGN BELOW.

SPOUSAL ACKNOWLEDGEMENT: I RUSSELL W. CLOTHIER, being the spouse of the above named person, acknowledge either Option 1 or 2 was selected.

[Signature]
Signature of Spouse

8/25/08
Date

☐ Option 3: A reduced monthly benefit payable for my lifetime. Upon my death, my joint annuitant (spouse or financial dependent), if living, will receive a lifetime monthly benefit payment in the same amount as I was receiving. (Exception: The benefit paid to a joint annuitant under age 25, who is not your spouse, will be your option one benefit amount. The benefit will stop when your joint annuitant reaches age 25, unless disabled and incapable of self-support, in which case the benefit will continue for the duration of the disability.) No further benefits are payable after both my joint annuitant and I are deceased.

The social security number of my joint annuitant is _____.

☐ Option 4: An adjusted monthly benefit payable to me while both my joint annuitant (spouse or financial dependent) and I are living. Upon the death of either my joint annuitant or me, the monthly benefit payable to the survivor is reduced to two-thirds of the monthly benefit received when both were living. (Exception: The benefit paid to a joint annuitant under age 25, who is not your spouse, will be your option one benefit amount. The benefit will stop when your joint annuitant reaches age 25, unless disabled and incapable of self-support, in which case the benefit will continue for the duration of the disability.) No further benefits are payable after both my joint annuitant and I are deceased.

The social security number of my joint annuitant is _____.

I understand I must terminate all employment with FRS employers to receive a retirement benefit under Chapter 121, Florida Statutes. I also understand that I cannot add service, change options or change my type of retirement (Regular, Disability and Early) once my retirement becomes final. My retirement becomes final when any benefit payment is cashed, deposited or when my Deferred Retirement Option Program participation begins.

Member Signature (sign in the presence of a Notary) [Signature]

Notary: State of Florida, County of Collier The above named person has sworn to and

subscribed before me this 26th day of August 2008 and is personally known ☒ or

produced _____ as identification.

Glennnda K. Roberts
Signature of Notary Public - State of Florida



Print, Type or Stamp _____

Florida Retirement System Pension Plan
Beneficiary Designation Form
(Retired Members Only)

PO Box 9000
Tallahassee FL 32315-9000
(850) 488-5207
Toll Free: (877) 377-4347

DATE RECEIVED

NOV 19 2008

RISK MANAGEMENT

Member Name Downs, Vickie A

Member SSN 316-45-5886

Please list your beneficiaries below. Return the original of the form to us and keep a copy for your records. If this form does not meet your individual needs, call the Division of Retirement.

When you retire, benefits due for the month of your death will be paid to your estate. Any benefits due after the month of death are payable to the designated beneficiary on file in our office.

1. Primary Beneficiary(s) Indicate percentages if naming more than one primary beneficiary.

Beneficiary	SSN	Relationship	Birthdate	Sex	%
A. <u>Vickie A Downs Rev Trust</u>					
B. <u>Russell W Cloniker</u>	<u>[REDACTED]</u>	<u>HUSBAND</u>	<u>11/25/47</u>	<u>M</u>	
C. _____					

2. Contingent Beneficiary(s) Indicate percentages if naming more than one contingent beneficiary.

Beneficiary	SSN	Relationship	Birthdate	Sex	%
A. _____					
B. _____					
C. _____					

3. For FRS Option 2 Retirees Only: If you wish to name joint beneficiaries and a contingent beneficiary for a particular primary beneficiary, use this block. (Please do not complete blocks 1 & 2 if you are completing this block.)

Primary Beneficiary _____	Date of Birth _____	% _____	Primary Beneficiary _____	Date of Birth _____	% _____
Primary Beneficiary SSN _____	Relationship _____		Primary Beneficiary SSN _____	Relationship _____	
Contingent Beneficiary _____	Date of Birth _____	% _____	Contingent Beneficiary _____	Date of Birth _____	% _____
Contingent Beneficiary SSN _____	Relationship _____		Contingent Beneficiary SSN _____	Relationship _____	

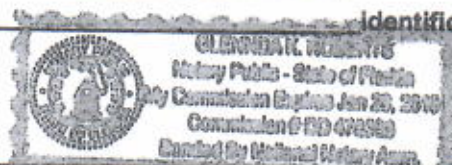
This form must be signed and acknowledged before a notary public.

Member Signature (sign in the presence of a Notary) [Signature]

Notary:

State of Florida County of Collier The above named person who has sworn to and subscribed before me this 16th day of November 20 08 and who is personally known X or produced _____ identification.

[Signature]
Signature of Notary Public



Print, Type or Stamp Commissioned Name of Notary Public

Florida Retirement System Pension Plan
Salary Certification



P O Box 9000
Tallahassee FL 32315-9000
850 488-6491 Toll Free 888 738-2252

☒ Final Salary Certification

☐ Amended Salary Certification

Agency
Number **21004**

Member
Name **VICKIE A DOWNS**

Member
SSN

Instructions for Completion

1. Certify the last four months salary earned prior to termination for Service Retirement or DROP begin date.
2. Certify salary by check/warrant date for all regular (non-DROP) retirements. List all regular salary payments, including overtime. Certify the lump sum annual leave payment in the designated area.
3. Certify prorated deferred salary payment made prior to the DROP begin date. Certify all salaries earned prior to DROP begin date.
4. If a salary adjustment or correction is made after this form is submitted, please submit an amended salary certification.
5. Do not certify any payments on which retirement contributions are not required. (See the following page for additional information.)

The completed form should be faxed [850 410-2196] to the Division of Retirement, no later than the fifth of the month following termination or DROP begin date. If you fax this form, do not mail the original. Call the above numbers if you have any questions.

Employee Pay Period: Biweekly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> BiMonthly <input type="checkbox"/> Other, specify <input type="text"/>		Termination Date or the day before the DROP Begin Date 09/30/2008	
Check/Warrant Date	Salary Paid	Comments	Lump Sum Annual Leave Payment
10/10/2008	\$1,903.85	THRU 9/30	$\frac{\text{Hours Paid}}{\text{Hourly Rate}} = \text{Lump sum Payment}$ (Do not include this payment in the salary paid column.)
09/26/2008	\$3,807.69		
09/12/2008	\$3,692.30		
08/29/2008	\$3,692.30		
08/15/2008	\$3,692.30		
08/01/2008	\$3,692.30		
07/18/2008	\$3,692.30		
07/03/2008	\$3,692.30		
06/20/2008	\$3,692.30		
06/06/2008	\$3,692.30		
			To be completed only by School Boards, Community Colleges and State Universities This member is employed on a 9 10 11 12 month basis. Contract Salary \$

Certified by: Melinda Roberts Date: **09/30/2008** Agency Phone: **(239) 252-8532**

Florida Retirement System Pension Plan
Deferred Retirement Option Program (DROP)
Termination Notification

PO Box 3090, Tallahassee, FL 32315-3090
(850) 487-4856 Toll Free (877) 738-3767 Fax (850) 410-2199



Member Verification:

Member Name: VICKIE A DOWNS
Mailing Address: 4660 LAKEWOOD BLVD
NAPLES, FL 34112

Member SSN: XXX-XX-5886
Home Telephone Number: 239-289-0835

According to our records, your DROP termination date is 09/30/13. You must terminate all Florida Retirement System (FRS) employment to receive your accumulated DROP benefits and begin your monthly retirement benefits. You and your employer's authorized representative must complete this form certifying your DROP employment termination.

Termination Requirement:

In order to satisfy your employment termination requirement, you must terminate all employment relationships with all participating FRS employers for the first 6 calendar months after your DROP termination date. Termination requirement means you cannot remain employed or become employed with any FRS covered employer in a position covered or non-covered by retirement for the first 6 calendar months following your DROP termination date. This includes but is not limited to: part-time work, temporary work, other personal services (OPS), substitute teaching, adjunct professor or non-Division approved contractual services.

Reemployment Limitation:

You may return to work for a participating FRS employer during the 7th - 12th calendar months following your DROP termination date, but your monthly retirement benefit will be suspended for those months you are employed. There are no reemployment limitations after the 12th calendar month following your DROP termination date.

If you fail to meet the termination requirement, you will void (cancel) your retirement and DROP participation and you must repay all retirement benefits received (including accumulated DROP benefits). If you void your retirement, your employer will be responsible for making retroactive retirement contributions and you will be awarded service credit for the period during which you were in DROP through your new employment termination date. You must apply to establish a future retirement date. Your eligibility for DROP participation will be determined by your future retirement date and you may lose your eligibility to participate in DROP.

This is to acknowledge that I will terminate or have terminated employment with my FRS employer on 9/30/13.
This further acknowledges that I have read and understand the above statements.

Member Signature: (Sign in the presence of a Notary) [Signature]

Notary:

State of Florida, County of Collier. The above named person has sworn to and subscribed before me this 15th day of July 20 13 and who is personally known [Signature] as identification.

Signature of Notary Public

Print, Type or Stamp Commissioned Name of Notary Public



Employer Certification of Employment Termination:

This is to certify that the DROP participation for the above named member will terminate or has terminated on 9/30/13 with the Agency, who I am authorized to represent.

Authorized Signature: [Signature] Position Title: DIRECTOR OF ACCOUNTING
Print Name: DONALD L. BERRY Phone Number: 239-252-8532
Agency Name: COLLIER COUNTY PROPERTY APPRAISER Agency #: 21004 Date: 7/15/13