ACCUMULATED LEAVE BALANCE TRANSFER OPTION
MUST BE SUBMITTED CALENDAR YEAR PRIOR TO CEASING EMPLOYMENT

In accordance with the provisions of the law and agreements governing the operation of the City of Miami General Employees' & Sanitation Employees' Retirement Trust Fund. I, _____

SSN (last 4 digits) _____, take the below specified **IRREVOCABLE**, voluntary option in

connection with the balances of my accumulated leave time. Should I elect to rollover the balances of my accumulated leave time I understand that I must elect, ***within 30 calendar days of my retirement***, to rollover the specified accumulated leave balances into an individual retirement account described in Section 408(a) of the Internal Revenue Code, an individual retirement annuity described in Section 408(b) of the Internal Revenue Code, an annuity plan described in Section 403(a) of the Internal Revenue Code, a qualified trust described in Section 401(a) of the Internal Revenue Code, or an eligible deferred compensation plan described in Section 457 (b) of the Internal Revenue Code which is maintained by an eligible employer described in Section 457 (e)(i)(A) of the Internal Revenue Code, that accepts the distributee's eligible rollover distribution.

Sick Time Balance
Transfer to G.E.S.E (check one) ☐ Yes ☐ No

Vacation Time Balance (includes 25 Years of Service Bonus)
Transfer to G.E.S.E (check one) ☐ Yes ☐ No

Earned Time Balance
Transfer to G.E.S.E (check one) ☐ Yes ☐ No

Signature* _____ Date* _____

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____day of _____, 20_____ by _____.

Personally Known _____ OR Produced Identification _____ Type of Identification Produced _____

(NOTARY SEAL) _____
(Signature of Notary Public)

*Indicates a required field

2901 Bridgeport Avenue Coconut Grove, Florida 33133-3607 (305)441-2300 Fax (305)441-2307 www.gese.org

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If I, _____ SSN* (last 4 digits) _____

should die before rolling over my accumulated leave balances, the following person(s) shall receive these balances.

1) Name* _____ Relationship _____

Date of Birth* _____ SSN* _____

2) Name _____ Relationship: _____

Date of Birth _____ SSN _____

In the event the above named person(s) predecease me, I further designate as **Contingent** beneficiary(ies) the following person(s):

1) Name* _____ Relationship _____

Date of Birth* _____ SSN* _____

2) Name _____ Relationship _____

Date of Birth _____ SSN _____

In the event the all the foregoing beneficiaries predecease me, then my leave time balances shall be paid to my estate.

Signature* _____ Date* _____

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____day of _____, 20_____ by _____.

Personally Known _____ OR Produced Identification _____ Type of Identification Produced _____

(NOTARY SEAL) _____
(Signature of Notary Public)

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