ROLLOVER INFORMATION FORM

This Form to be completed and returned to the Department of Fire & Police Pensions within 90 days from DROP exit date.

Name:_____ Social Security #: _____

FINANCIAL INSTITUTION RECEIVING ROLLOVER DISTRIBUTION

(To be completed by financial institution.)

PLEASE NOTE: PLACE ONLY ONE CHARACTER PER BOX, SPACE LIMITED ON PRINTED CHECKS.

I certify that this retirement plan will accept this direct rollover from the Fire & Police Pension Plan, that this retirement plan is eligible to receive these funds, and that the following information is accurate:

Name of the recipient institution: _____

Mailing Address:

City:

State: **Zip Code:**

Please provide the "Check Payable To" information; i.e., "[Full name of your company] as Trustee of the IRA of [account owner's name]":

Account #:

Financial Institution Officer:

_____ _____

PRINT NAME & TITLE PHONE #

_____ _____

SIGNATURE DATE

PLEASE READ AND SIGN BELOW (**To be completed by person requesting rollover**.)

I understand that I am responsible for providing the Fire & Police Pension Department with the correct information for a direct rollover and that the plan designated above is a "qualified retirement plan" eligible to receive a direct rollover.

_____ Date: _____

Signature-Person Requesting Rollover