

Rollover Acceptance Form
Florida Municipal Pension Trust Fund 457(b) DC Plan

SECTION 1

Employee Name	Social Security Number	Date
Rollover Amount		

MARK SOURCE OF ROLLOVER -- Florida Municipal Pension Trust Fund 457(b) DC Plan accepts rollovers from the following sources:

- A qualified plan described in section 401(a) of the Code
- A plan described in section 403(a) of the Code
- A plan described in section 403(b) of the Code
- An eligible plan under section 457(b) of the Code which is maintained by a state, political subdivision of a state or any agency or instrumentality of a state or political subdivision of a state
- Participant Rollover Contribution from an IRA (pre-tax amounts only)

Checks must be made payable to **TDA TRUST COMPANY FBO Florida Municipal Pension Trust Fund 457(b) DC Plan FBO your name** and attach it to this form. Mail the check, this form and any documentation to your Plan Sponsor. Check with your employer to determine if any additional forms are needed to complete your request. Your rollover will start earning gains or losses in the investment funds you have selected as soon as it is deposited and the check has cleared.

SECTION 2 - TO BE COMPLETED BY EMPLOYEE

Name of Former Plan (Transferor Plan) _____

As a participant in the above referenced plan, I represent that: (1) the transferor plan is the type of plan indicated above; (2) the transferor plan has satisfied such requirements as the transferee plan may have established for the purpose of reasonably concluding the eligibility for acceptance of the transferred amount under the transferee plan; and (3) I understand that these rollover funds, once deposited in the Plan, will be subject to all provisions of the Plan, including all distribution restrictions, unless a protected optional form of benefit within the meaning of IRC Section 411(d)(6).

I understand that my rollover contribution must be made within 60 days after receiving the distribution from the other plan or the IRA. By signing and dating below, I hereby verify that I received this rollover within the last 60 days.

Signature _____ Date _____

SECTION 3 - TO BE COMPLETED BY ACCEPTING EMPLOYER

Signature of Plan Representative _____

Name of Plan Representative _____

Date _____ Telephone _____

Please retain a copy for your records and remit to your employer.