PR-13
Rev. 07/06
Disability Determination

Florida Retirement System
Investment Plan Application for Disability Retirement

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Applicant Name: _____ Applicant SSN: _____

Street/PO Box Address: _____ Birth Date: _____

_____

_____ E-Mail: _____

City/State/Zip: _____ Phone: ____ / _____

Present (or last) employer: _____

Title of position held: _____

Last Day Actually Worked: _____ Last Date in Pay Status: _____ Termination Date: _____

Type of Disability Benefit You Are Applying For: ☐ **Regular** ☐ **In-Line-of-Duty**

Describe the illness or injury, which has caused your disability and how it prevents you from performing your usual job duties.

_____

_____

_____

1. Educational Background--Circle the highest grade level you have completed:
Grammar School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 Graduate School: 1 2 3 4 Other:

2. Work History--List your two previous jobs prior to your current employment:

Job: _____ From: ___/___/___ To: ___/___/___
Job: _____ From: ___/___/___ To: ___/___/___

3. If you have any other physical impairments, please describe them and the length of time they have existed:

_____

_____

4. If you have made any Workers' Compensation claims, please list date(s) of accident(s) and employer(s).

Date: _____ Employer: _____
Date: _____ Employer: _____

List the names, addresses, and phone numbers of the physicians currently or most recently treating you:

A. Name of Physician & Address:

_____

_____

_____

_____

Phone: _____

A. Name of Physician & Address:

_____

_____

_____

_____

Phone: _____

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Disability Determination

Florida Retirement System
Investment Plan Application for Disability Retirement

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Member Name _____ Member SSN _____

Authorization for Release of Information: I hereby apply for disability retirement benefits. This application is being made because of a disability, which incapacitates me for the performance of any useful work; and I affirm that all information and statements are true and correct to the best of my knowledge.

I hereby authorize any physician, hospital, or clinic to give full and complete information concerning me, or my medical condition, including any prior history to the Division of Retirement, State of Florida, or its authorized representative.

In addition to the above general medical release, I hereby specifically authorize the release of any records, which may exist concerning me, including but not limited to, employment or personnel records with previous employers, including records with a School Board, Community College, or Public School System, or records with other Retirement Systems, the Veteran's Administration, Social Security Administration, Workers' Compensation records, or any other records, which a personal release signed by me may be required. Please cooperate with the bearer of this release. This Authorization for Release of Information is valid throughout the duration of my claim/retirement.

Date: _____ Applicant Signature: _____

Option Selection: You may complete a Form PR-11o, Investment Plan Option Selection for FRS Members, and submit it, along with your application to select an option; or you may wait until an estimate of benefits is provided. A Disability Estimate will be provided if you are approved for disability benefits. However, in the event of your death prior to filing an Option Selection Form, by law, your option selection will default to Option 1, which does not provide a benefit to your beneficiary. If you select an option, you may change the option selection at any time until a benefit payment has been cashed or deposited. You must provide us with your joint annuitant's date of birth to have Options 3 and 4 calculated.

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	_____	Primary SSN	_____
Relationship	_____	Primary Birthdate	_____
Contingent	_____	Contingent SSN	_____
Relationship	_____	Contingent Birthdate	____/____/____

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** change my retirement option once my retirement becomes final. My retirement becomes final when any benefit payment is cashed or deposited. **I understand that in order to receive disability benefits, all monies accumulated in my Investment Plan account will be transferred to the Division of Retirement for deposit in the disability account of the Florida Retirement System Trust Fund.** I understand as a disabled retiree, I cannot work in any capacity and receive a disability benefit. I acknowledge that I have read and understand the Instructions Pages 1 and 2.

Applicant Signature: (sign in the presence of a Notary) _____

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

_____ _____
Signature of Notary Public Print, Type or Stamp Commissioned Name of Notary Public

FR-13A
Rev. 07/06
Disability Determination

Florida Retirement System
Statement of Disability by Employer

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Applicant Name _____ Applicant SSN _____

Position Title _____

This form should be completed and signed by the designated person in your personnel office.

Date of Employment _____ Agency Name _____

Last Day Worked _____ _____

Last Day in Pay Status _____ _____

Termination Date _____ _____

Was the applicant able to perform all duties of this position prior to the illness or injury?
Yes ____ No____

If not, please explain _____

_____

_____

Has the applicant discussed with your personnel office the possibility of moving into another position with your agency which would be within the applicant's medical limitations? Yes ____ No____

If so, what positions were identified? _____

_____

_____

Why was this position not accepted? _____

_____

_____

_____

Type of disability: Regular ☐ In-Line-of-Duty ☐

Rule 60S-4.007, F.A.C.

FR-13A
Rev. 07/06
Disability Determination

Florida Retirement System
Statement of Disability by Employer

Applicant Name: _____ Applicant SSN: _____

If the applicant is applying for **in-line-of-duty** disability retirement please provide:

(1) A copy of the pre-employment physical examination, if any.

(2) Copies of all First Report of Injury or Notice of Injury Forms filed with Workers' Compensation or Risk Management.

(3) Copies of any Orders signed by a Deputy Commissioner, Rehabilitation Reports and medical documentation relative to the applicant's claim for in-line-of-duty disability.

Comments: _____

Authorized Signature: _____ Date: _____

Name (print): _____ Address: _____
Office Location

Title: _____

Phone: _____

Form FR-13B
Rev 07/19
Rule 60S-4.007

Florida Retirement System
Physician's Report

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Applicant Name _____ Applicant SSN _____

Position Title _____ Employer _____

Check One:

Regular Disability: ☐ Florida Statutes, Chapter 121.091(4)(b), Total and permanent disability. "A member shall be considered totally and permanently disabled if, in the opinion of the administrator, he is prevented, by reason of a medically determinable physical or mental impairment, from rendering useful and efficient service as an officer or employee."

In-Line-Of-Duty Disability: ☐ Florida Statutes, Chapter 121.021(13), "Disability in line of duty means an injury or illness arising out of and in the actual performance of duty required by a member's employment during regularly scheduled working hours or irregular working hours as required by the employer . . ."

Authorization for release of medical information

I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

_____ _____
Applicant Signature Date

Physician's Statement

The patient is responsible for completion of this form without expense to the State of Florida. Please provide any additional information and copies of your office notes, if you feel they are pertinent to an understanding of this patient's condition. However, office notes CANNOT be submitted in lieu of properly completing page two of this form.

License Number _____ _____
Issued By Florida Board of Medical Examiners Physician's Name (Please print)

Specialty _____ Address _____

Fax _____ _____

Phone _____ _____

Form FR-13B
Rev 07/19
Rule 60S-4.007

Florida Retirement System
Physician's Report

Applicant Name: _____ Applicant SSN: _____

1. **Diagnosis:**

a) When did you first treat this patient? Date: _____

b) Date of most recent examination: _____

c) Primary disabling condition: _____

_____

d) Secondary condition(s): _____

_____

e) What restrictions have you placed on the patient's activities? _____

2. **Prognosis:**

a) Has the patient's condition stabilized? Yes _____ No _____

b) Has the patient reached maximum medical improvement? Yes _____ No _____

c) If so, when did the patient reach maximum medical improvement? Date _____

d) Is the patient a candidate for vocational rehabilitation? Yes _____ No _____

e) Additional comments: _____

3. **Physical and/or Mental Impairment:**

_____ No limitation of functional capacity; may return to work.

_____ Slight limitation of functional capacity; capable of light work.

_____ Moderate limitation of functional capacity; capable of sedentary work.

_____ Cannot perform present work, but capable of performing another line of work.

_____ Temporary limitation of functional capacity; temporarily incapable of any kind of work; temporarily disabled from gainful employment.

_____ Limitation of functional capacity to the extent that the member is permanently prevented by reason of a medically determinable physical or mental impairment from rendering useful and efficient service as an officer or employee.

4. **In-Line-Of-Duty:** (Complete only if "in-line-of-duty" disability retirement was checked on opposite page and injury arose out of the performance of duty. All four questions must be answered.)

a) Is the patient's primary disability due to an on-the-job injury or illness? _____

b) If so, what was the date of the injury? _____

c) How do you relate the primary disability to the on-the-job injury? _____

d) Is there any cause other than the on-the-job injury contributing to the patient's disability? Please explain: _____

_____

Additional Comments: _____

_____

_____ _____ _____

Physician's Signature | Physician's Name (Please Print) | Date

Form FR-13B
Rev 07/19
Rule 60S-4.007

Florida Retirement System
Physician's Report

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Applicant Name _____ Applicant SSN _____

Position Title _____ Employer _____

Check One:

Regular Disability: ☐ Florida Statutes, Chapter 121.091(4)(b), Total and permanent disability. "A member shall be considered totally and permanently disabled if, in the opinion of the administrator, he is prevented, by reason of a medically determinable physical or mental impairment, from rendering useful and efficient service as an officer or employee."

In-Line-Of-Duty Disability: ☐ Florida Statutes, Chapter 121.021(13), "Disability in line of duty means an injury or illness arising out of and in the actual performance of duty required by a member's employment during regularly scheduled working hours or irregular working hours as required by the employer . . ."

Authorization for release of medical information

I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

_____ _____
Applicant Signature Date

Physician's Statement

The patient is responsible for completion of this form without expense to the State of Florida. Please provide any additional information and copies of your office notes, if you feel they are pertinent to an understanding of this patient's condition. However, office notes CANNOT be submitted in lieu of properly completing page two of this form.

License Number _____ _____
Issued By Florida Board of Medical Examiners Physician's Name (Please print)

Specialty _____ Address _____

Fax _____ _____

Phone _____ _____

Form FR-13B
Rev 07/19
Rule 60S-4.007

Florida Retirement System
Physician's Report

Applicant Name: _____ Applicant SSN: _____

1. **Diagnosis:**

a) When did you first treat this patient? Date: _____

b) Date of most recent examination: _____

c) Primary disabling condition: _____

_____

d) Secondary condition(s): _____

_____

e) What restrictions have you placed on the patient's activities? _____

2. **Prognosis:**

a) Has the patient's condition stabilized? Yes _____ No _____

b) Has the patient reached maximum medical improvement? Yes _____ No _____

c) If so, when did the patient reach maximum medical improvement? Date _____

d) Is the patient a candidate for vocational rehabilitation? Yes _____ No _____

e) Additional comments: _____

3. **Physical and/or Mental Impairment:**

_____ No limitation of functional capacity; may return to work.

_____ Slight limitation of functional capacity; capable of light work.

_____ Moderate limitation of functional capacity; capable of sedentary work.

_____ Cannot perform present work, but capable of performing another line of work.

_____ Temporary limitation of functional capacity; temporarily incapable of any kind of work; temporarily disabled from gainful employment.

_____ Limitation of functional capacity to the extent that the member is permanently prevented by reason of a medically determinable physical or mental impairment from rendering useful and efficient service as an officer or employee.

4. **In-Line-Of-Duty:** (Complete only if "in-line-of-duty" disability retirement was checked on opposite page and injury arose out of the performance of duty. All four questions must be answered.)

a) Is the patient's primary disability due to an on-the-job injury or illness? _____

b) If so, what was the date of the injury? _____

c) How do you relate the primary disability to the on-the-job injury? _____

d) Is there any cause other than the on-the-job injury contributing to the patient's disability? Please explain: _____

_____

Additional Comments: _____

_____

_____ _____ _____

Physician's Signature | Physician's Name (Please Print) | Date

PR-11o
Rev. 02/10
Disability Determination

Florida Retirement System Pension Plan
Option Selection for Disability Retirement

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

To apply for disability retirement, you must submit the following forms:

Form PR-13, *Investment Plan Application for Disability Retirement*--To apply for disability retirement benefits, you must provide the Division of Retirement with a properly signed and completed disability application. Since your effective retirement date is primarily determined by the date the Division receives your disability application, you may send your application to us before the other forms are completed. Effective retirement dates are established as follows:

If you are no longer employed, and your disability application is not received within thirty days of your termination date, your effective retirement date will be the first day of the month following the date we receive your application.

If your disability application is received within thirty days of your termination date, your effective retirement date will be the first day of the month following your termination date.

If you are currently employed (in a Florida Retirement System (FRS)-covered position), your effective retirement date will be the first day of the month following the date we receive your disability application or the first day of the month following the last month for which salary is reported or creditable service is granted.

Form FR-13a, *Statement of Disability by Employer*--This form must be completed and signed by the designated person in your personnel office.

Form FR-13b, *Physician's Report*--As proof of disability, Statute 121.091(4) requires two different Florida licensed physicians who have treated you for your disabling condition to attest to your total and permanent disability.

If you are approved for disability benefits, the total balance in your Investment Plan (IP) account will be transferred to the FRS Trust Fund, and you will be placed back in the FRS Pension Plan (PP). You are not eligible for disability benefits if you previously received a distribution from your IP account. Once you receive any distribution from your IP account, you are considered to have retired from the FRS (Exception: Mandatory Distribution of a De Minimis Account). If you return to FRS employment in the future, you will be considered a renewed member, and renewed members are not eligible for disability.

The FRS provides two types of disability retirement benefits: In-line-of-duty and regular. You are covered for in-line-of-duty disability retirement from your first day of employment. If your injury or illness arose out of and in the actual performance of your job duties, you may apply for in-line-of-duty disability benefits. Your physicians must attest you are totally and permanently disabled due to an on-the-job injury or illness and you must provide us with a copy of the Notice of Injury as filed with Workers' Compensation. You must have eight years of creditable service to be eligible for regular disability retirement.

To qualify for disability retirement benefits provided for by the FRS, a member must be totally and permanently disabled from performing useful and efficient service as an officer or an employee upon termination from FRS covered employment as required by Section 121.091(4), Florida Statutes. Approval for Social Security disability or Workers' Compensation does not automatically qualify you for disability retirement benefits under the FRS. The unavailability of an employment position that you are physically and mentally capable of performing will not be considered as proof of total and permanent disability.

It must be documented that:

1. Your medical condition occurred or became symptomatic during the time you were employed in an employee/employer relationship with your employer;
2. You were totally and permanently disabled at the time you terminated FRS covered employment; and
3. You have not been employed with any other employer after such termination.

You are responsible for having all forms completed by the proper persons and submitted to the Division of Retirement. Questions concerning the filing of this application may be directed to the Disability Determination Section. The Administrator is authorized by law to make investigations and to require additional information, as needed, to reach a decision on your application. Failure to thoroughly complete all items may result in a delay in your claim. You may obtain the forms by calling the Disability Determination Section at the Division of Retirement or by e-mailing Disability@dms.myflorida.com .

Rule 60S-4.007, F.A.C.

Florida Retirement System Pension Plan
Option Selection for Disability Retirement

If approved for disability retirement, all of the following are required before your name can be added to the retired payroll:

1. To receive a disability retirement benefit, you must terminate all employment with all FRS and non-FRS employers.

2. Please designate your beneficiary on the attached PR-13, *Investment Plan Application for Disability Retirement*. All previous beneficiary designations are null and void.

3. A properly completed Form PR-11o, *Investment Plan Option Selection for FRS Members.* You may select an option when you submit your disability application or you may wait until an estimate of benefits is provided. A Disability Estimate will be provided if you are approved for disability benefits. However, in the event of your death prior to filing an Option Selection Form, by law your option selection will default to Option 1, which does not provide a benefit to your beneficiary. If you select an option, you may change the option selection at any time until a benefit payment has been cashed or deposited.

   You must provide us with your joint annuitant's date of birth to have Options 3 and 4 calculated. Read carefully the description of each option.

   Option 1 is a monthly benefit payable for your lifetime. Upon your death, the monthly benefit will stop and your beneficiary will receive only a refund of any contributions you have paid, which are in excess of the amount you received in benefits, not including the member's transferred Investment Plan balance. Option 1 does not provide a continuing benefit to your beneficiary.

   Option 2 is a reduced monthly benefit payable for your lifetime. If you die prior to receiving 120 monthly payments, your designated beneficiary will receive a monthly benefit in the same amount as you were receiving until the monthly benefits payable to both you and the beneficiary equal 120 monthly payments. If you die after you have received 120 monthly payments, there is no continuing benefit to the beneficiary. Anyone can be named as a beneficiary under Option 2, as well as charities, organizations, or your estate or trust.

   Option 3 is a reduced monthly benefit payable to you for your lifetime. Upon your death, your joint annuitant, if living, will receive a lifetime monthly benefit payment in the same amount as you were receiving.

   Option 4 is an adjusted monthly benefit payable to you while you and your joint annuitant are living. Upon the death of either you or your joint annuitant, the monthly benefit to the survivor is reduced to two-thirds of the monthly benefit received when both were living.

   Exception to Options 3 and 4: The benefit paid to a joint annuitant under age 25, who is not your spouse, will be your Option 1 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. If you are naming someone other than a spouse under Options 3 or 4, please obtain Form JAD, *Joint Annuitant Information,* from the Division of Retirement. The amount of reduction for Options 3 and 4 depend on your age and the age of your joint annuitant.

4. Proof of your birth date. If you select Option 3 or 4, you must also submit birth date verification for your beneficiary. We will accept legible photocopies of **one** of the following:
   a. Birth Certificate
   b. Delayed birth certificate
   c. Census report more than 30 years old
   d. Life insurance policy more than 30 years old
   e. Letter from the Social Security Administration stating the date of birth it has established for the payment of benefits
   f. Certificate of Naturalization
   g. In the absence of one of the above, a document from **two** of the following categories will be required:

      (1) Birth certificate of child, showing age of parent (limit one)
      (2) Baptismal certificate more than 30 years old
      (3) Hospital record of birth
      (4) School record at time of entering grammar school
5. A final certification of your earnings by your employer for the last four months of your employment. **Your employer is aware of this requirement.**

6. Direct Deposit of your benefit is available through the State's Electronic Funds Transfer (EFT) program. An application will be mailed to you after your name has been added to the Retired Payroll. If you are a State employee, currently on EFT, you wil l automatically continue on EFT unless you cancel your authorization.

PR-11o
Rev. 02/10
Disability Determination

Florida Retirement System Pension Plan
Option Selection for Disability Retirement

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Member Name: _____ Member SSN: _____

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, not including my transferred Investment Plan account balance. This option does not provide a continuing monthly benefit to my beneficiary.

☐ **Option 2:** A reduced monthly benefit payable for my lifetime. If I die before receiving 120 monthly payments, my designated beneficiary will receive a monthly benefit in the same amount as I was receiving until the monthly benefit payments to both of us equal 120 monthly payments. No further monthly benefits are then payable.

☐ **Option 3:** A reduced monthly benefit payable for my lifetime. Upon my death, my joint annuitant 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 monthly 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 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 ___/___/___.

PLEASE COMPLETE FORM SA-2

I understand I must terminate all employment with FRS employers and **cannot** be employed with any employer to receive a disability retirement benefit under Chapter 121, Florida Statutes. I also understand that I **cannot** change options once my retirement becomes final. My retirement becomes final when any benefit payment is cashed or deposited.

Member Signature: (*Sign in the presence of a Notary*) _____

Notary:

State of _____, County of _____. The above named person who has sworn to and subscribed before me this _____ day of _____ 20 _____ and who is personally known _____ or produced _____ identification.

_____
Signature of Notary Public

_____
Print, Type or Stamp Commissioned Name of Notary Public

SA-2
Rev. 02/10
Disability Determination

Florida Retirement System Investment Plan
Spousal Acknowledgment Form for Disability Retirement

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Member Name _____ Member SSN _____

CHECK ONE OF THE FOLLOWING:

MARRIED: ☐ YES ☐ NO IF YES AND YOU SELECTED OPTION 1 OR 2, YOUR SPOUSE MUST ALSO COMPLETE BOX 2.

Notarized Signature of Member: _____

1 **Notary:** State of Florida, County of _____. The above named person who has sworn to and subscribed before me this _____ day of _____ 20 _____ and is personally known _____ or produced _____ as identification.

_____ _____
Signature of Notary Public - State of Florida Print, Type or Stamp Commissioned Name of Notary Public

SPOUSAL ACKNOWLEDGMENT: I, _____ being the spouse of the above named member, acknowledge that the member has selected either Option 1 or 2.

Notarized Signature of Spouse: _____

2 **Notary:** State of Florida, County of _____. The above named person who has sworn to and subscribed before me this _____ day of _____ 20 _____ and is personally known _____ or produced _____ as identification.

_____ _____
Signature of Notary Public - State of Florida Print, Type or Stamp Commissioned Name of Notary Public

The following is an explanation of all four Florida Retirement System Options:

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

Option 2: A reduced monthly benefit payable for my lifetime. If I die before receiving 120 monthly payments, my designated beneficiary will receive a monthly benefit in the same amount as I was receiving until the monthly benefit payments to both of us equal 120 monthly payments. No further monthly benefits are then payable.

Option 3: A reduced monthly benefit payable for my lifetime. Upon my death, my joint annuitant 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 monthly benefits are payable after both my joint annuitant and I are deceased.

Option 4: An adjusted monthly benefit payable to me while both my joint annuitant 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.

Rule 60S-4.007, F.A.C.