FLORIDA DEPUTY SHERIFFS ASSOCIATION

Florida Deputy Sheriffs Association
Post Office Box 12519
Tallahassee, FL 32317-2519
Office 850-877-2165
1-800-877-2168
Fax 850-878-8665
www.fldeputysheriffs.org

Please check one

❑ **Basic Membership @ $25 per year** (not payroll deductible)

❑ **Enhanced Membership @ $25 per month**

Complete and mail application to address at right. Basic Members include a check or money order (Enhanced is payroll deducted).

Date: ___ /___ /____ Time of Day: ________________ SSN: ______ - ______ - ______ Date of Birth: ___ / ___ / ____

Name: ____ ❑ Certified ❑ Non-Certified
Last First MI

Home Address/P.O. Box: ____________________________________ Apt or Unit #: ______________

City: ______________________ State: ______________ Zip: ______________ Gender: ________

Employer: ______________________ Occupation: ______________________ Gross Annual Salary: __________

Home Phone: ____________________________ Work Phone: ____________________________

Cell Phone: ______________________ Email: ____________________________________

Spouse's Name: ____ Date of Birth: ___ / ___ / ____
Last First MI

Does your spouse work for a Florida Sheriff's Office? _____ Yes _____ No

If yes, which county? ______________________ Occupation: ______________________

Dependents: ____ Date of Birth: ___ / ___ / ____
Last First MI

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Last First MI

Dependents: ____ Date of Birth: ___ / ___ / ____
Last First MI

Dependents: ____ Date of Birth: ___ / ___ / ____
Last First MI

Applicant's Primary Beneficiary(ies)

____ Date of Birth: ___ / ___ / ____
Last First MI

Relationship: ______________________ SSN: ______ - ______ - ______ % (total must equal 100%): ____________

____ Date of Birth: ___ / ___ / ____
Last First MI

Relationship: ______________________ SSN: ______ - ______ - ______ % (total must equal 100%): ____________

Applicant signature: ____

Primary Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among surviving beneficiaries.

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Enhanced Membership

I hereby authorize my employer ____

To recognize and accept the Florida Deputy Sheriffs Association dues in the amount of $25 per month for Enhanced Membership to be deducted from my pay/salary.

Print Name: ____ Date: ____ / ____ / ____

Applicant Signature: ____ SSN: ______ - _____ - ______

Add Identity Theft (additional $10 per month): ____ Yes ____ No

Revised 7/25/11