



**BROWARD HEALTH  
REQUEST FOR RETIREMENT INFORMATION**

Please complete the following information and have this form signed by your Supervisor/Department Head. Submit the signed notification form with your proof of age to the Human Resources Department. It is important that you contact the Benefits Department at [benefits@BrowardHealth.org](mailto:benefits@BrowardHealth.org) to schedule an appointment prior to your last day of work. This will help ensure accurate processing of your retirement benefits.

NAME: \_\_\_\_\_ EMPLOYEE #: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ COST CENTER #: \_\_\_\_\_

Do you wish to receive the Retiree Recognition gift? YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby submit notification of my intent to retire from Broward Health. My last day of active work will be \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
Supervisor/Department Head

**FOR HUMAN RESOURCES USE ONLY:**

DATE OF: COUNSELING SESSION \_\_\_\_\_

ATTACHMENTS: Proof of Birth: \_\_\_\_\_ Life Insurance Beneficiary Form: \_\_\_\_\_

Employee/Joint Annuitant (if applicable): \_\_\_\_\_

COMMENTS:

Human Resources Representative: \_\_\_\_\_

Date Forwarded to Benefits: \_\_\_\_\_

**PROOF OF AGE:**

Please submit a copy of one of the documents listed below as proof of your age.

1. Official Birth Certificate
2. Naturalization Certificate
3. Passport