



Fraternal Order of Police

Application for membership

John Nelson Memorial Pasco Lodge 29
4300 Land O Lakes Boulevard
Land O Lakes, FL 34639
FOPPascoLodge29@gmail.com
PascoFOP.com

Secretary Use Only

Received: _____

Accepted: _____

Updated 12/2021

Membership Type: Full Active Associate (FOPA):

LAST NAME: FIRST NAME: M.I.

HOME ADDRESS:

CITY: STATE: ZIP:

MOBILE/CELL:

PERSONAL EMAIL:

SSN: DOB: MALE: FEMALE:

Current/Previous Law Enforcement Agency:

Current Work Location (Check if Not Applicable):

Law Enforcement: Corrections:

Active: Retired: Resigned: Other: Note:

Full Active Membership Type (select one):

Fraternal Only*: Fraternal + Legal Defense Only**: Fraternal + Legal + Labor***:

*Retired members

**Captains and above

***Active local law enforcement

Will you be utilizing agency payroll deduction to pay dues? YES: NO:

Emergency Contact Name:

Relationship:

Emergency Contact Address:

Emergency Contact Telephone:

Emergency Contact Email:

Application Check List:

- \$25.00 Application Fee (Cash Check Credit Card – Online at PascoFOP.com)
- Application for Membership to F.O.P. John Nelson Memorial Pasco Lodge 29
- Florida State Lodge Application for Membership & Membership Oath
- Standard Insurance – Enrollment Change Form
- Legal Defense Plan Application (If Applicable)
- 2022 Payroll Deduction Authorization Form (If Applicable)

Signature: _____ Date: _____

**FLORIDA STATE LODGE
FRATERNAL ORDER OF POLICE**

Application for Membership

(For all new local Lodge members to be submitted with Per Capita tax)

NAME: _____

HOME ADDRESS: _____

CITY: _____ **ZIP:** _____

CELL PHONE #: _____

EMAIL ADDRESS: _____

MEMBERSHIP OATH

This is the oath that each member **must** take when becoming a member of the Fraternal Order of Police.

I, _____ (print your name), in the presence of the creator of the universe and the members of the Fraternal Order of Police here assembled, do most solemnly and sincerely promise and swear, that I will to the best of my ability comply with all the laws and rules of this order; that I will recognize the authority of my legally elected officers and abate all orders there from not in conflict with my religious or political views, or my rights as an American citizen; that I will not cheat, wrong, or defraud this order, or any member thereof, or permit the same to be done if in my power to prevent it; that I will at all times aid and assist a brother (or sister) in sickness or distress, so far as it lies in my power to do so; that I will not divulge any of the secrets of this order to anyone not entitled to receive them. To all of which I most solemnly and sincerely promise and swear. Should I violate this, my solemn oath or obligation, I hereby consent to be expelled from the order.

Signature: _____

Date: _____

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

A P P L I C A N T	Your Name (Last, First, Middle)		Group Name Pasco County Sheriff's Lodge #29		Group Number(s) 142825	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	

L I F E	Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.					
	Life Insurance <input checked="" type="checkbox"/> Life with AD&D Employer Paid					

B E N E F I C I A R Y	This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit

C H A N G E	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.					
	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent		<input type="checkbox"/> Name Change		<input type="checkbox"/> Beneficiary Change	
Date of add/delete _____		Former name _____		<input type="checkbox"/> Other _____		

S I G N A T U R E	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	

Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr
---------	--------------	---------------------	---------------------	-------------------	--

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated _____.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.

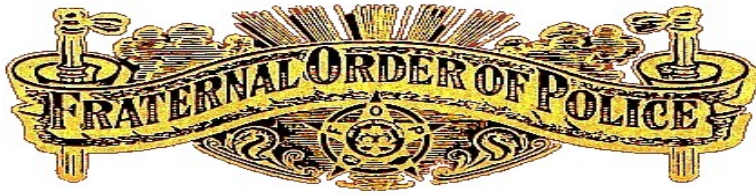
**DO NOT RETURN THIS PAGE. IT IS FOR YOUR
INFORMATION ONLY!**

**IF YOU HAVE ANY QUESTIONS PLEASE
CONTACT THE LODGE SECRETARY:**

W. SCOTT HUMPHREY

757-651-4831

PASCOLODGE29SECRETARY@GMAIL.COM



LEGAL DEFENSE PLAN APPLICATION

Lodge Name and Number _____

Member Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Last 4 digits of Social Security#: _____

I hereby apply for enrollment in the FOP-FL Labor Council Committee Labor/Legal Defense Plan (LDP), and agree to abide by all the terms and conditions thereof. ***I understand that no coverage is in effect until this application is approved by my Lodge President. To my knowledge, I am not presently named in any suits, action or proceeding or under investigation for a duty-related incident with the following exception.***

Member Signature: _____

Date: _____

Lodge President Printed Name: _____

Lodge President Signature: _____ Approved Date: _____

Membership must be through local Lodges. All completed **and** approved applications must be sent with payment.

Option 1: \$90.00 per quarter per person

Option 2: \$180.00 Bi-Annually **OR**

Option 3: \$360.00 Annually

Mail to:

Fraternal Order of Police
FL Labor Council Committee
242 Office Plaza
Tallahassee, FL 32301

Fraternal Order of Police



*John Nelson Memorial Pasco Lodge 29
4300 Land O Lakes Boulevard, Land O Lakes, FL 34639
(813) 406-5611
foppascalodge29@gmail.com*

Payroll Deduction Authorization Form

I, _____, do authorize the Zephyrhills Police Department to deduct \$ _____ from my paycheck each and every pay period and pay the amount to:

The Fraternal Order of Police – John Nelson Memorial Pasco Lodge 29

I understand this amount will be paid towards my Fraternal Lodge Membership and the Florida Labor Council Legal Defense Plan (LDP) & Labor I have selected below:

_____ Participate in FOP – John Nelson Memorial Pasco Lodge 29 **Fraternal Lodge Membership** of \$11.35 per pay period **plus** the **Florida Labor Council Legal Defense Plan (LDP)** and **Labor Union** at the rate of \$15.09/per pay period. Membership dues for this selection is \$26.44/per pay period.

_____ Participate in FOP – John Nelson Memorial Pasco Lodge 29 **Fraternal Lodge Membership** of \$11.35 per pay period **plus** the **Florida Labor Council Legal Defense Plan (LDP)** at the rate of \$12.23/per pay period. This option **does not** include Labor Union and generally only applies to Captains and above. Membership dues for this selection is \$23.58/per pay period.

_____ Participate in FOP – John Nelson Memorial Pasco Lodge 29 **Fraternal Membership** only at the rate of \$11.35/per pay period. Membership dues for this selection is \$11.35/per pay period. This option generally only applies to retirees and/or non-sworn personnel.

_____ Participate in FOPA – John Nelson Memorial Pasco Lodge 29 **Associate Membership** only at the rate of \$2.50/per pay period. This option generally only applies to non-sworn personnel. Membership dues for this selection is \$2.50/per pay period.

Signature: _____

CJIS Number: _____

D120821ate: _____