PAROCHIAL EMPLOYEES'
RETIREMENT SYSTEM OF
LOUISIANA

Please provide a copy of the following along with your application:

1. Driver's License and Social Security Card
2. Updated Electronic Deposit Form – must include voided check or letter from bank.
3. Updated W-4P for federal withholding
4. Marriage License (IF APPLICABLE)
5. Member Death Certificate
6. Beneficiary's Birth Certificate

APPLICATION FOR BENEFIT FOR SURVIVIING SPOUSE/MINOR OF AN ACTIVE MEMBER

SECTION 1: SURVIVOR INFORMATION (Application Must Be Completed in Full)

Name

Date of Birth

Social Security Number

Current Mailing Address

City

State

Zip Code

Email

Phone

Survivor Signature

Date

Relationship to Member

SECTION 2: MEMBER INFORMATION

Member Name

Date of Birth

Date of Death

Social Security Number

SECTION 3: TO BE COMPLETED ONLY IF MEMBER WAS ACTIVE - NOT RETIRED

Selection of Benefit - Initial One Option Only

Initials

A.________ **A.** If the member was eligible to retire, select the **monthly** survivor benefit due me pursuant to R.S. 11:1945.

B.________ **B.** In lieu of any benefits due me as a survivor, I elect the option to receive a refund of the member's accumulated contributions and expressly waive any right to a monthly benefit.

SECTION 4: NOTARY

SWORN TO AND SUBSCRIBED BEFORE ME, Notary Public, in and for the state of ________________, parish/county of,

this ___________ day of ________________, 20_____.

Notary Public (Signature)

Notary ID # or Bar Roll #

Notary Public Name

Commission Expires

PERS PAROCHIAL EMPLOYEES' RETIREMENT SYSTEM OF LOUISIANA

SELECT THE PLAN THAT APPLIES:

_____**PLAN A** _____**PLAN B**

EMPLOYER FORM – TO BE COMPLETED BY EMPLOYER

USE THIS FORM TO REQUEST ONE OF THE FOLLOWING – CHOOSE ONLY ONE OPTION

Regular Retirement Benefit	Disability Benefit	Deferred Retirement Option Plan (DROP)	Post-DROP

EMPLOYEE INFORMATION		
First:	Middle (or Maiden):	Last:
Social Security No. :	Date of Birth:	Telephone:
Address:	City, State, Zip:	
Email Address:		
Employer:	Department:	

TO BE COMPLETED BY EMPLOYER	
Employee's Continuous Service Started on:	Date:
DISABILITY ONLY - Employee will have used all Accumulated Annual Leave on:	Date:
Last Day on Parish Payroll **(N/A for DROP)**:	Date:
Effective Date of Benefit (Retirement/DROP to Commence):	Date:

Unused & Unpaid Accumulated Leave for Conversion to Retirement credit = ________________days.

***********LEAVE RECORDS MUST BE INCLUDED***********

OVERTIME PAY- LIST THE AMOUNT OF OT BY MONTH FOR THE 7 YEARS BEFORE RETIREMENT DATE

Specify year here>>>>>>>>	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7 (current)
January							
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							

Did the member have ANY leave without pay since the date of hire? YES NO

If yes, provide the number of hours and time periods the leave without pay occurred below.

____

____

____

Signature of Applicant Date

____

Name and Title of Appointing Authority Submitting This Form

____

Signature of Employer Date

Actuarial Approval:

PAROCHIAL EMPLOYEES' RETIREMENT SYSTEM OF LOUISIANA

NOTICE:
All changes made *after* the 15th will take effect in the following month.

AUTHORIZATION FOR DIRECT DEPOSIT

Must attach a VOIDED check or Direct Deposit Authorization Form from the Financial Institution

BENEFIT RECIPIENT'S INFORMATION

First Name:	Middle Initial:	Last Name:
Mailing Address:		
City:	State:	Zip Code:
Last 4 Digits of SSN:		Phone Number:
Email Address:		

ACCOUNT INFORMATION

Name of Financial Institution:	
Type of Account: ☐ Checking ☐ Savings	
Must attach a VOIDED check or Direct Deposit Authorization Form from the Financial Institution	
Account Number:	Routing Number: (Must Be 9 Digits)
Address of Financial Institution:	
City: State:	Zip Code:
If Joint Account, Name of Joint Signer:	

I hereby authorize Parochial Employees' Retirement System (PERS) to deposit my net benefit payment to my account at the financial institution designated above and, if necessary, to initiate withdrawals to correct erroneous deposit entries to my account listed above. I understand that it is my responsibility to notify PERS should any changes occur to the above account specified. This authorization remains in effect until another signed Authorization for Direct Deposit is completed and received by PERS terminating or changing payment instructions. By signing below, I certify the following: 1) that the entire payment amount of my direct deposit is not ultimately deposited into a financial institution outside of the U.S.; 2) that I am entitled to the payment identified herein; and 3) that I understand the provisions and obligations contained herein.

Signature of Benefit Recipient **Date of Signature**