

**RETIREMENT APPLICATION CHECKLIST**

THIS FORM SHOULD BE RETURNED AND SIGNED WITH THE COMPLETED ORIGINAL APPLICATION FOR RETIREMENT. APPLICATIONS RECEIVED WITHOUT THE PROPER PAPERWORK FILLED OUT COMPLETELY WILL DELAY PROCESSING OR BE RETURNED AS INCOMPLETE. PLEASE INCLUDE THE FOLLOWING WITH YOUR RETIREMENT APPLICATION.

**Name:**

***Forms REQUIRED for an eligible member to apply for regular retirement.***

	*Original Notarized DROP Retirement Application
	*Original Maximum Affidavit – If applicable
	*Original Employer Form <i>(for each current employer)</i>
	*Original Designation of DROP Beneficiary Form
	*Original Options Explanation

***A copy of the following items are REQUIRED for an application to be considered completed.***

	*Copy of Member’s Driver’s License or other Government Issued Identification
	*Copy of Beneficiary’s Driver’s License or other Government Issued Identification
	*Copy of Member’s Social Security Card
	*Copy of Beneficiary’s Social Security Card
	*Copy of Member’s Birth Certificate
	*Copy of Beneficiary’s Birth Certificate
	*Copy of Marriage License if the applicant is married
	*CERTIFIED Copy of Divorce Judgement or Copy of Spouse’s Death Certificate
	*Copy of Leave Records if converting leave
	*Please provide the member’s normal work schedule. For example, M-F 8AM-5PM, 4 (10s) if shift work, please describe in detail.

***Date of Retirement and Last Date of Active Service***

	Confirm that date of retirement and last day of active service are NOT the same
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I hereby confirm that all items on this checklist are included in this application. I acknowledge that any omissions or incomplete information may result in processing delays or the application being returned as incomplete.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Date

## **DROP RETIREMENT APPLICATION CHECKLIST EXPLAINED**

### Original Notarized Retirement Application

- The member must choose a benefit option in Section 2.
- If the member is married at the time of applying, the spouse is **REQUIRED** to sign Section 2 indicating they agree to the option regardless of which option the member chooses.
- If an option other than the Maximum is chosen, Section 3 must be completed with the beneficiary's information.
- A notary **MUST** complete the Notary section.

### Original Employer Form

- The employer **MUST** complete the sections labeled "to be completed by employer."
- The member and an appointing authority for the employer must sign the form.
- If a member intends to convert unused and unpaid leave to retirement credit, the number of days to convert **MUST** be noted on the form. Leave conversion is subject to the provisions of the employer's leave policy.

### Original Maximum Affidavit

- **ONLY** if the Maximum Option is chosen, the member and two witnesses **MUST** sign the form.

### Designation of DROP Beneficiary Form

- This beneficiary only applies prior to DROP fund distribution.

### Original Option Explanation

- Must be signed by **BOTH** employer and applicant.

### CERTIFIED Copy of Divorce Judgement or Copy of Spouse's Death Certificate

- Whatever is applicable, if member was ever married during participation in PERS and Marital Status has changed.

### Copy of Leave Records if converting leave

- A copy of the member's leave records for at least the previous 12 months indicating the amount of leave available for their use at the time of retirement **MUST** be submitted.

**SELECT THE PLAN THAT APPLIES:**

\_\_\_ PLAN A    \_\_\_ PLAN B

Date of Application: \_\_\_\_\_

**APPLICATION FOR DEFERRED RETIREMENT OPTION PLAN - DROP**

**SECTION 1 – MEMBER’S INFORMATION (Application Must Be Completed in Full)**

To the Board of Trustees:

In accordance with the provisions of the Parochial Employees' Retirement System law, I hereby make application for the Deferred Retirement Option Plan:

APPLICANT INFORMATION			
First Name:	Middle (or Maiden):	Last Name:	
Social Security No.: <b>MUST Attach copy of card</b>	Date of Birth:	Telephone:	
Mailing Address:		City, State, Zip:	
Email Address:			
Marital Status – Must Select ONE option. <input type="checkbox"/> Never Married <input type="checkbox"/> Legally Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
SECTION 2 – GENERAL INFORMATION			
1. Selection is hereby made of the retirement benefit payment plan chosen below: <u>(Please see page 2 for explanation of benefit options)</u>			
<input type="checkbox"/> Maximum Allowance <input type="checkbox"/> Option Number _____ (Choice must be written in blank - Option No. 2, 3, or 4)			
1. Date that applicant desires DROP to begin: _____			
<b>I hereby certify that all the information provided above is true and correct.</b>			
<b>Applicant's Signature:</b>			

**SECTION 3 – RETIREMENT BENEFICIARY INFORMATION**

In the event of my taking the lesser allowance provided under an option, the following beneficiary is to receive any payable monthly benefits at my death:			
First Name:	Middle (or Maiden):	Last Name:	
Social Security No.: <b>Attach copy of card</b>	Date of Birth:	Relationship:	
Mailing Address:		City, State, Zip:	
Email Address:			Telephone:
I hereby acknowledge that I am fully aware that if the above-named DROP participant has either chosen an option that does not provide for a death beneficiary or designated someone other than myself, DROP participant's legal spouse, as beneficiary(ies) of the DROP participant's monthly retirement benefit with the Parochial Employees' Retirement System I will not receive a monthly benefit upon DROP participant's death. I further acknowledge and consent to such designation(s), without limitation.			
<b>Legal Spouse's Signature:</b>			

**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



## Option Explanation

Please Note:

- DROP entry date shall not take effect earlier than thirty days prior to the date of application is received in the office (not the date of mailing).
- Applications are not accepted any earlier than ninety days from the date of the filing of the application.

OPTIONS:

Maximum Option

- Upon retirement for service, any participant may elect to receive his benefit in a Maximum Allowance payable through life, or he may elect at that time to receive the actuarial equivalent of his retirement allowance in a reduced allowance payable throughout life with the provision that:

Option No. 2.

- Upon his death, his reduced retirement allowance shall be continued throughout the life of and paid to such person as he shall have nominated by written designation duly acknowledged and filed with the Board of Trustees at the time of his retirement; or

Option No 3.

- Upon his death, one-half of his reduced retirement allowance shall be continued throughout the life of and paid to such person as he shall have nominated by written designation duly acknowledged and filed with the Board of Trustees at the time of his retirement; or

Option No. 4

- Some other benefit or benefits shall be paid either to the participant or to such person or persons as he shall have nominated provided such other benefit or benefits, together with the reduced retirement allowance, shall be certified by the actuary to be of equivalent actuarial value of his retirement allowance, and approved by the Board.

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**A retiree cannot change the designation of beneficiary.**

No Change in the option elected by the member, other than to correct administrative error shall be permitted after 60 days from the date of receipt of retirement application by the Board.

**IMPORTANT!** Copy of member's birth certificate must accompany this application. Should an option plan be chosen, copy of beneficiary's birth certificate must also be submitted.

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### IMPORTANT NOTICE ABOUT DROP

**DROP entry begins on the first calendar day of a month and ends on the last calendar day of a month (regardless of the day of the week). DROP deposits are credited only for full calendar months you remain actively employed while in DROP. If your retirement/separation date is any day other than the last calendar day of the month, no DROP deposit will be paid for that month (there is no pro-ration for partial months). If you continue working AFTER DROP, no post-DROP calculation will be due if you work less than 3 weeks after your DROP participation ends (this includes leave conversion).**

**The above computations and benefits have been explained to me and I fully understand all of the above.**

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Applicant's Signature

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Employer Signature



**MAXIMUM OPTION AFFIDAVIT**

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DATE \_\_\_\_\_

STATE OF LOUISIANA

PARISH OF \_\_\_\_\_

This is to certify that I have chosen the Maximum Benefit on my application for retirement or DROP and I understand that this choice means that my monthly benefit is for my lifetime only and no survivor benefits will be paid after my death.

\_\_\_\_\_  
Signature

Witnesses: (if married, one witness must be legal spouse)

\_\_\_\_\_

\_\_\_\_\_

**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:
<b>DISABILITY ONLY</b> - 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.	
<b>*****LEAVE RECORDS MUST BE INCLUDED*****</b>	

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:**

\_\_\_\_\_

\_\_\_\_\_

**DESIGNATION OF DEFERRED RETIREMENT OPTION PLAN BENEFICIARY**

Member Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_

**To the Board of Trustees:**

In accordance with the provisions of the Parochial Employees' Retirement System of Louisiana law, I hereby designate the below named person as my beneficiary to receive a refund of my DROP lump sum if I die prior to payment of the lump sum amount. I understand that if I do not specify a beneficiary for this purpose, the beneficiary designated as my Option beneficiary will be deemed the beneficiary for this purpose also. If I have no option beneficiary and do not specify a beneficiary for this purpose, I understand that the DROP lump sum will be paid to my estate.

Beneficiary Name:	Social Security No. :
Relationship:	Date of Birth:
Mailing Address:	City/State/Zip:

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

Name: \_\_\_\_\_

Notary No.: \_\_\_\_\_ ; My commission expires: \_\_\_\_\_

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**SPOUSAL AFFIDAVIT (Only complete if non-spouse beneficiary above named.)**

State of Louisiana, Parish of \_\_\_\_\_.

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally came and appeared \_\_\_\_\_ (spouse/affiant), who after being duly sworn did depose and state as follows:

I acknowledge that my spouse (PERS member) has made the above beneficiary designation and I understand it. This election is made with my full knowledge and consent.

Affiant Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Affiant's Social Security Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

Name: \_\_\_\_\_

Notary No.: \_\_\_\_\_ ; My commission expires: \_\_\_\_\_