Form MSD52
R092019

PRINT ALL INFORMATION
www.lasersonline.org

LASERS
Louisiana State Employees' Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
225.935.2856 (fax)

Certification for Disabled Survivor

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

SECTION 1: RECIPIENT'S INFORMATION (TO BE COMPLETED BY APPLICANT)

RECIPIENT INFORMATION

Recipient's First Name	Middle Name	Last Name	☐ Male ☐ Female	Social Security Number

Recipient's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Birth Date

LIVING PARENT / LEGAL GUARDIAN OF RECIPIENT INFORMATION

First Name of Parent / Legal Guardian	Middle Name	Last Name	Social Security Number

Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address

SECTION 2: RECIPIENT'S CERTIFICATION AND AUTHORIZATION

I hereby authorize and consent to the named physician to release any and all information relative to the recipient to the Louisiana State Employees' Retirement System, for the purpose of verifying eligibility for benefits. I also verify that no other state benefits are being received. If other state benefits are being received, please attach documentation and forward to LASERS as soon as possible.

Recipient or Guardian's Signature	Date

Social Security Number

SECTION 3: INSTRUCTIONS

To the ATTENDING PHYSICIAN - Please type or print all information and complete sections 4 and 5. Failure to do so will result in a delay of benefits. Return the completed form to LASERS at the above mailing address.

SECTION 4: DIAGNOSIS AND CONDITION (TO BE COMPLETED BY PHYSICIAN)

Please state the diagnosis and condition of recipient:

SECTION 5: REMARKS AND RECOMMENDATIONS (TO BE COMPLETED BY PHYSICIAN)

Please check one:

It is my opinion that this person was fully physically or mentally disabled as of the LASERS member's date of death, _____, and is dependent on a parent or legal guardian for daily needs.

☐ Yes
☐ No

Name of Attending Physician | **Specialty/Degree** | **Daytime Area Code/Phone Number**

Mailing Address | **City** | **State** | **Zip Code**

Signature of Physician (Rubber Stamp is NOT Acceptable) | **Date**

Reset Form