Form 6-03
R082010

DO NOT FAX FORM
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

OPT2BDES

Option 2B Mentally Handicapped Designee

As a LASERS retiree with a mentally handicapped child, you may provide that your child receives a benefit upon your death. By choosing the 2B retirement option, you name a designated beneficiary who will receive a benefit upon your death. Upon the death of that beneficiary, a benefit will be continued throughout the life of your mentally handicapped child. This benefit will be paid to the child's named guardian.

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

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: DESIGNATED BENEFICIARY INFORMATION (To be completed by applicant)

Beneficiary's Name | **Beneficiary's Birth Date** | **Beneficiary's Security Number**

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

Daytime Area Code/Phone Number | **Evening Area Code/Phone Number**

☐ **Female**
☐ **Male**

SECTION 2: MENTALLY HANDICAPPED CHILD'S INFORMATION (To be completed by applicant)

Child's Name | **Child's Birth Date** | **Child's Security Number**

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

Daytime Area Code/Phone Number | **Evening Area Code/Phone Number**

☐ **Female**
☐ **Male**

Is child currently married? ☐ **Yes** ☐ **No**

SECTION 3: MEMBER'S CERTIFICATION AND AUTHORIZATION

I hereby authorize that the physician below may release any and all information relative to my mentally handicapped child to the Louisiana State Employees' Retirement System for the purpose of verifying eligibility for benefits.

Member's Signature | **Date**

SECTION 4: INSTRUCTIONS TO CHILD'S PHYSICIAN

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

Social Security Number

SECTION 5: DIAGNOSIS AND CONDITION (To be completed by the physician)

Please state the diagnosis and condition of the child:

If the child has a mental disability, is it caused by:

Birth Defect	☐ **Yes**	☐ **No**
Traumatic Injury	☐ **Yes**	☐ **No**
Result of Medication	☐ **Yes**	☐ **No**
Psychiatric Condition	☐ **Yes**	☐ **No**

What is the prognosis?

SECTION 6: PHYSICIAN'S INFORMATION AND CERTIFICATION

Name of Attending Physician

Degree/Specialty

Mailing Address

City

State

Zip Code

Physician's Signature (stamp is NOT acceptable)

Date

Daytime Area Code/Telephone Number

Reset Form