Form 10-2A
R112014

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

Re-employment of Disability Retiree
(La. R.S. 11:224 and 11:225)

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: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

Are you receiving a benefit from another state or statewide retirement system? ☐ **Yes** ☐ **No**

If you answered "Yes" to the question above, list the name of the state or statewide system(s) from which you are receiving benefits:

SECTION 2: SELECTION OF DISABILITY RE-EMPLOYMENT OPTION

I elect the following option during the period of my re-employment after retirement. I will notify LASERS immediately if any condition of my re-employment changes. **(INITIAL ONLY ONE)**

Initials ☐ I elect to return to active service. I understand that my Disability retirement allowance shall cease, I will again become a member of the retirement system and shall contribute at the rate in effect at the time that I return to service. Should I be unable to continue employment and choose to seek Disability retirement, I must reapply according to the applicable laws.

Initials ☐ I elect to return to active service for a trial period of no more than six months with no effect other than the suspension of the retirement allowance during this period of re-employment. I will be an actively contributing member to LASERS during this time. If I am unable to work more than six months, my retirement allowance shall be reinstated without the necessity of any reapplication for Disability retirement or medical exam. My contributions paid during this trial period will be refunded to me. If I continue working for six months or longer, my Disability benefits will be terminated and retirement contributions will continue.

SECTION 3: MEMBER SIGNATURE

I hereby certify that the employment information is correct to the best of my knowledge.

Member's Signature	Date

Social Security Number

SECTION 4: AGENCY CERTIFICATION

I hereby certify that the employment information stated below is correct to the best of my knowledge.

Date Employed

Number of Hours/Week

Employment Status (Check one):

☐ **Full Time** ☐ **Part Time**

Name of Personnel Officer

Title

Name of Agency

3 Digit Agency Number

Email Address of Personnel Officer

Daytime Area Code/Phone Number

Signature of Personnel Officer

Date

Reset Form