Form 4-02
R092013

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LASERS
Louisiana State Employees' Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
225.922.0612 (hearing impaired) Fax 225.935.2856

Disability Retirement Waiver to Remain on Leave

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

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

SECTION 2: WAIVER

I understand that I have been approved for Disability Retirement and I am eligible to begin receiving a monthly disability retirement benefit.

I understand that in lieu of terminating state service and receiving a monthly disability benefit, I have opted to remain on sick and/or annual leave.

I understand that by remaining on leave, I am waiving my right to any disability benefit for the period of time that I remain on leave.

I understand that, until I terminate state service, I will not be considered retired and that the named beneficiary under the retirement option I selected, if any, will not be entitled to any benefits under such option unless I retire prior to my death.

I understand that if I continue to actively work in state service (as opposed to remaining on leave) or if I return to active work in state service, whether prior to or after exhausting my sick and annual leave, I will be considered as having been restored to active service. I understand that I must submit a Form 10-02A, *Reemployment of Disability Retiree*.

I understand that if I am restored to active service, I will be subject to the provisions of La. R.S. 11:224 and 11:225, and my retirement benefit will be suspended or terminated.

I understand that if I remain on leave, I must submit Form MSD12, *Annual Attending Physicians Statement*, after being evaluated by a physician, after one year from the date of my disability retirement application.

SECTION 3: MEMBER SIGNATURE

I certify that I have read and understand the waiver in Section 2.

Member's Signature	Date

Social Security Number

SECTION 4: AGENCY CERTIFICATION

I certify that the member named above will remain on leave until electing to terminate state service.

Name of Personnel Officer	Title	Name of Agency	Agency 3 digit Number

Mailing Address	City	State	Zip Code

Signature of Personnel Officer	Date	Daytime Area Code/Phone Number

Reset Form