Form 6-02
R102013

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
225.922.0612 (hearing impaired) Fax 1.225.935.2856

Insurance Premium Deduction Authorization

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: RETIREE'S INFORMATION

Type of Retirement (Check one): ☐ **Regular** ☐ **Actuarially Reduced** ☐ **DROP** ☐ **IBO** ☐ **Disability** ☐ **Survivor**

Retiree's Name | **Social Security Number** | **Do you currently have Medicare coverage?** ☐ **Yes** ☐ **No**

If yes, do you have ☐ **Part A and/or** ☐ **Part B**

Daytime Area Code/Phone Number | **Evening Area Code/Phone Number** | **Email Address** | **Date of Birth**

Member's Mailing Address | **City** | **State** | **Zip Code**

Name of Dependent Spouse (if applicable) | **Date of Birth** | **Does spouse currently have Medicare coverage?** ☐ **Yes** ☐ **No**

If yes, is it ☐ **Part A and/or** ☐ **Part B**

I hereby authorize the Louisiana State Employees' Retirement System to deduct from my monthly retirement check the amount as may now or hereafter be payable by me for the State Employees Group Benefits Program insurance premiums.

Member's Signature | **Date**

SECTION 2: AGENCY CERTIFICATION

It is advisable to deduct or require payment for one additional month after termination to allow for processing authorization.

Premiums Paid Through | **Date of Termination** | **Name of Agency** | **Group Number**

Signature of Personnel Officer | **Title** | **Date**

RETIREMENT OFFICE USE ONLY

Effective Date of Retirement | **Annual Salary at Time of Retirement**

Date of First Check | **Verified by (Analyst)** | **Date**

INSURANCE OFFICE USE ONLY

Type of Coverage
Please note date through which premiums have been paid

Reset Form