LASERS
Louisiana State Employees' Retirement System

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

Disability Application Checklist

This checklist should be used as a guideline in preparing to submit a Disability Application and supporting documentation.

- ☐ Disability must have occurred while in active state service
- ☐ Must be unable to perform your work duties
- ☐ Must meet your Plan's number of years of service eligibility requirement (10 years for Regular Plan members)
- ☐ Must complete the following parts of the Disability Application and submit to LASERS
  - ◯ *Form 04-01, Disability Retirement Application* - Completed by you, the member
  - ◯ *Form 04-01A, Disability Report* - Completed by your immediate supervisor
- ☐ Should submit *Form 04-01B, Attending Physician's Statement for Disability Retirement* - Completed by your attending physician
- ☐ Should submit all pertinent medical records along with the application. These may take weeks to attain from your physician, so you should plan accordingly. LASERS will not delay sending your application for medical review if the medical records are not submitted along with the application.
- ☐ Should attach a copy of your most recent Civil Service Job Description to your Disability Application before submission to LASERS. Your Human Resources department can provide you with a copy.

Parts 04-01 and 04-01A of the *Disability Retirement Application* must be complete in order for LASERS to consider your application valid. If these parts of the application are incomplete, you will have 10 business days to submit a complete application. After 10 business days, LASERS will close your case and you must reapply by submitting a new application and meeting all eligibility requirements.

RETAIN COPY FOR YOUR RECORDS

Form 4-01
R042023

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Disability Retirement Application

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

Would you like your address changed to the above if it does not match our records? ☐ **Yes** ☐ **No**

Home Area Code/Phone Number	Mobile Area Code/Phone Number	Email Address	Member's Birth Date

☐ **Female** ☐ **Male** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

List your claimed disability:

SECTION 2: INSTRUCTIONS (This is the first of three forms to be completed, along with Forms 4-1A and 4-1B)

Any person who, knowingly and with intent to defraud an insurance company or another person, files a statement containing any materially false information or conceals information for the purpose of misleading, concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Claimant's Initial Statement of Disability -- Be sure to answer all questions. Failure to do so may delay your claim. The Form 4-01A, *Disability Report* must be completed by your agency and the Form 4-01B, *Attending Physician's Statement* should be completed by your attending physician or the physician's designee and submitted to LASERS at the address above.

LASERS strongly suggests that you obtain a disability benefits estimate **before** submitting this application and all required documents listed in Section 5 as your retirement option cannot be changed once the application is received in the LASERS office.

SECTION 3: MEMBER'S JOB INFORMATION

Job Title	Employing Agency	Total Years of Service

In your own words, please describe the usual duties of your job: (If additional space is needed, attach a separate sheet.)

Has your illness or injury caused you to change:

your job duties? ☐ **Yes** ☐ **No** **your hours of work?** ☐ **Yes** ☐ **No** **your attendance?** ☐ **Yes** ☐ **No**

Social Security Number

If yes, please identify the changes and their effective dates:

In your own words, briefly describe the accident or illness that prevents, or prevented, you from working:

Date of First Treatment for the Disability

Is your condition due to an accident?

☐ Yes ☐ No

Date of Accident

Location of Accident: ☐ Home ☐ Work ☐ Other:

If the condition was due to an accident, describe how the accident occurred:

SECTION 4: MEMBER'S ATTENDING PHYSICIAN INFORMATION

Regarding your disability, what is your consulting physician's major area of specialty? **Mark only one.**

☐ Internal Medicine ☐ Orthopedics ☐ Psychiatry ☐ Cardiology ☐ Neurology ☐ Oncology

☐ Rheumatology ☐ Other (specify)

List the physician(s) who has your most recent medical records. If more than one, attach additional sheets.

Name of Attending Physician | Speciality/Degree | Date First Visited Doctor | Date Last Visited Doctor

Mailing Address | City | State | Zip Code | Daytime Area Code/Phone Number

Is this your primary care physician?

☐ Yes ☐ No

If no, give name and address of your primary care physician:

Give name, address, and telephone number of any other doctors you have seen since your disability began:

Has a doctor told you to restrict your activities in any way? ☐ Yes ☐ No

If yes, list what he/she told you about restricting your activities:

Social Security Number

Were you hospitalized? ☐ **Yes** ☐ **No**

If yes, list the hospital name and days of confinement:

Describe how any home duties, social activities, or ability to care for your personal needs are limited in any way:

List the name, address, and telephone number of any facilities where you have been seen for your injury or illness (Workers' Compensation Board, vocational rehab, social services, etc.):

Dates of Visits	**Claim Number, if any**	**Type of Treatment or Examination Received**

SECTION 5: GENERAL INFORMATION

LASERS **requires** the following documents to complete the processing of your application:

1) Copy of Social Security cards for member and beneficiary
2) Copy of birth certificates for member and beneficiary
3) Certified Divorce Decree, if applicable
4) Certified Matrimonial Contracts, Prenuptial Agreements, Separate Property Agreements, etc., if applicable
5) Copy of death certificate of former spouse, if applicable
6) Form 4-04, *Spousal Consent,* if applicable
7) Form 6-03, *Option 2B Designee*, if applicable
8) Form 4-05, *Authorization for Direct Deposit*
9) W-4P, *Withholding Certificate for Pension or Annuity Payments.* This form is not required. If the form is not submitted to LASERS, your federal tax withholding will be set as Single with no adjustments.

NO RETIREMENT BENEFITS WILL BE PAID UNTIL LASERS HAS RECEIVED ALL OF THE REQUIRED DOCUMENTS.

SECTION 6: SELECTION OF RETIREMENT PLAN OPTION (Choose one)

If you are a member of one of the following LASERS retirement plans, select this box only and do NOT select a retirement option below as your benefits are directed to survivors by statute:

Wildlife Agent
Hazardous Duty Services Plan
New Orleans Harbor Police

☐ Initials

RESTRICTION FOR MARRIED MEMBERS: If you are married and do not have a separate property agreement, you must choose a retirement option which provides a benefit for your spouse that is at least fifty percent (50%) of the benefit payable to you. You may choose another option or name someone other than your spouse as your beneficiary if your spouse agrees with the choice and signs Form 4-04 *Spousal Consent*, **in the presence of a Notary Public** (La. R.S. 11:446 (F)).

Social Security Number

MAXIMUM PLAN pays you the highest lifetime monthly benefit and pays a lump-sum refund of any unused portion of your accumulated contributions to your named beneficiary(ies) upon your death. (Contributions are usually exhausted in approximately 2 years.) Attach Form 4-04 *Spousal Consent,* if applicable. Initials

OPTION 1 pays you a slightly reduced lifetime monthly benefit and pays a lump-sum of any unused portion of your accumulated contributions to your named beneficiary(ies) upon your death. (Contributions are usually exhausted in approximately 8 or more years.) Attach Form 4-04 *Spousal Consent,* if applicable. Initials

OPTION 2A pays you a benefit that is reduced from the Maximum Plan according to the age difference between you and your named beneficiary and pays the same monthly benefit to your named beneficiary after your death for the lifetime of the beneficiary. **Only one beneficiary can be named and the beneficiary cannot be changed after retirement.** Initials

OPTION 2B pays you a benefit that is reduced from the Maximum Plan according to the age differences between you, your named beneficiary, and your mentally handicapped child/children. Upon your death, a benefit is paid to your named beneficiary for life. Upon the death of the beneficiary, a benefit will be continued throughout the life of your mentally handicapped child/children. Form 6-03, *Option 2B Mentally Handicapped Designee* must be completed and submitted with this application. Initials

OPTION 3 pays you a benefit that is reduced from the Maximum plan according to the age difference between you and your named beneficiary and pays 50% of your monthly benefit to your named beneficiary after your death for the lifetime of the beneficiary. **Only one beneficiary can be named and the beneficiary cannot be changed after retirement.** Initials

OPTION 4B pays you a benefit that is reduced from the Maximum Plan according to the age difference between you and your named beneficiary and pays 55% of your monthly benefit to your named beneficiary after your death for the lifetime of the beneficiary. **Only one beneficiary can be named and the beneficiary cannot be changed after retirement.** Initials

SECTION 7: RETIREMENT BENEFICIARY INFORMATION

You can have multiple beneficiaries ONLY if you choose the Maximum or Option 1 Plan. If you have multiple retirement beneficiaries, do not complete this section. You must complete Form 1-06, *Designation of Beneficiary* to name multiple beneficiaries. If naming someone other than your spouse, please attach Form 4-04, *Spousal Consent.*

Full Name of Retirement Beneficiary | **Birthdate of Beneficiary** | **Social Security Number**

Mailing Address, City, State and Zip Code | **Relationship to Member** | ☐ **Male** ☐ **Female** | **Date of Marriage if applicable**

SECTION 8: MEMBER SIGNATURE AND AUTHORIZATION TO RELEASE INFORMATION

I authorize any employer, insurance company, Medical Insurance Bureau, Workers' Compensation Board, Social Security Administration, physician, practitioner, hospital, or health care institution to release to the Louisiana State Employees' Retirement System (LASERS) any medical information, which may be required to establish the validity of this claim. I also authorize such company, person or organization to disclose any relevant claim information required for the review of this claim. I agree that a photocopy shall be as valid as the original.

I have read and understand all pages of this application and certify that, to the best of my knowledge, all information provided on this document is true and correct. **I understand that my retirement option cannot be changed after the date this application has been received in the LASERS office.**

Member's Signature | **Date**

PLEASE ATTACH COPIES OF NECESSARY MEDICAL REPORTS/RECORDS TO THIS APPLICATION.

Reset Form

Form 4-01A
R072021

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Disability Report

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: INSTRUCTIONS

Answer **all** questions. The form must be signed by your supervisor and certified by your employing agency. This form should be attached to the Form 4-01, *Disability Retirement Application*, along with a copy of your Civil Service Job Description.

SECTION 2: TO BE COMPLETED BY YOUR IMMEDIATE SUPERVISOR

Civil Service Job Title

Briefly describe the disability applicant's actual duties:

Physical exertion required? ☐ **Extensive** ☐ **Moderate** ☐ **Light**

Climbing required? ☐ **Yes** ☐ **No**

Lifting required? ☐ **Yes** ☐ **No**

Was the disability a result of an injury or accident on the job? ☐ **Yes** ☐ **No**

If yes, was the injury sustained in the official performance of official duties? ☐ **Yes** ☐ **No**

If yes, is the member in the Hazardous Duty, Corrections Primary, Corrections Secondary, Wildlife, or Harbor Police Plan and was the injury due to an intentional act of violence? ☐ **Yes** ☐ **No**

If yes, submit Form 4-01C, *Certification of Disability Sustained from an Intentional Act of Violence*.

Are Worker's Compensation payments being received? ☐ **Yes** ☐ **No**

Specifically list the above stated duties that the applicant can no longer perform because of the disability:

Describe any special physical requirements:

Social Security Number

Describe the working conditions:

List specific information you have as to the date and cause of the disability:

When and how did the disability begin to affect the performance of the applicant's duties:

SECTION 3: SIGNATURE OF SUPERVISOR

Name of Supervisor | Title | Daytime Area Code/Phone Number

Signature of Supervisor | Date

SECTION 4: AGENCY SIGNATURE AND CERTIFICATION

Name of Personnel Officer | Name of Agency | Title

Personnel Officer Email Address | Daytime Area Code/Phone Number | Agency Three Digit Number

Signature of Personnel Officer | Date

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Form 4-01B
R072021

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Attending Physician's Statement for Disability Retirement

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: INSTRUCTIONS FOR PHYSICIAN

To the ATTENDING PHYSICIAN - Please attach all medical records, treatment notes, X-rays, and test results. **Failure to do so may result in delays to your patient.** The purpose of this report is to assist us in making a determination of disability. In completing this report, please include sufficient detail of history, physical and diagnostic findings, clinical course, and therapy to enable us to make this determination.

SECTION 2: PATIENT INFORMATION

Height	Weight	Member's Birth Date

Did the disability occur during employment?

☐ Yes ☐ No

SECTION 3: DIAGNOSIS

Primary Diagnosis _____

ICD10 Code	ICD10 Code Description

Secondary Diagnosis _____

ICD10 Code	ICD10 Code Description

ICD10 Code	ICD10 Code Description

List Detailed Subjective Symptoms. If needed, please attach additional sheets with "Subjective Symptoms," the patient's name, and Social Security number at the top:

SECTION 4: TREATMENT

Date of First Visit for this Illness/Injury	Date of Last Visit

Frequency of Current Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Nature and Dates of Treatment:

Social Security Number

SECTION 5: PROGRESS

Check one:

- ☐ Recovered
- ☐ Improved
- ☐ Unchanged
- ☐ Retrogressed

Present Status:

- ☐ Ambulatory
- ☐ House Confined
- ☐ Bed Confined
- ☐ Hospitalized

Indicate how activities are restricted:

If hospitalized, name of hospital and dates of confinement:

SECTION 6: EFFECT OF PHYSICAL/MENTAL IMPAIRMENT ON JOB DUTIES

Explain in sufficient detail the extent that the patient's illness or injury affects their capacity to perform current job duties:

What are the patient's current functional abilities in the following areas in hours (based on an 8-hour day)

Sitting _____ ☐ Continuously ☐ With Rests

Standing _____ ☐ Continuously ☐ With Rests

Walking _____ ☐ Continuously ☐ With Rests

Lifting ☐ 1-10 lbs. ☐ 10-25 lbs. ☐ 25-50 lbs. ☐ Over 50 lbs.

Cardiac Functional Capacity (if applicable). Rate based on American Heart Association Rules:

- ☐ Class 1 (no limitation)
- ☐ Class 3 (marked limitation)
- ☐ Class 2 (slight limitation)
- ☐ Class 4 (complete limitation)

Activities:	Never	Occasionally	Frequently	No Restriction
Bending	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Reaching above shoulder	☐	☐	☐	☐
Driving	☐	☐	☐	☐

_____ Blood Pressure _____

SECTION 7: REMARKS AND RECOMMENDATIONS *(YOU MUST ANSWER BOTH QUESTIONS)*

1. In my opinion, this employee is totally incapacitated from future performance of his/her normal job duties. ☐ **Yes** ☐ **No**

2. In my opinion, this employee should be retired. ☐ **Yes** ☐ **No**

SECTION 8: ATTENDING PHYSICIAN INFORMATION

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

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

Signature of Attending Physician | **Date**

Reset Form