Form 08-04
R042023

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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

Judicial Disability Retirement Application

(Complete if retiring from the Judicial Plan and if the first eligible date for membership in one of the four state retirement systems occurred prior to 1/1/2011.)

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

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

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

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* must be completed by your attending physician and submitted to LASERS at the address above. Attach a copy of your Social Security card and a copy of your Birth Certificate.

LASERS strongly encourages you to obtain a disability benefits estimate **before** submitting this application as you 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:

Last Date of Employment (if no longer employed)

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

Please 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 family doctor?

☐ Yes ☐ No

If no, give name and address of your family doctor:

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)

JUDICIAL MAXIUMUM

Select this box if you wish to retire under the Judicial Plan and have your survivor benefits directed by statute. ☐ Initials

REGULAR RETIREMENT OPTIONS

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 may have multiple beneficiaries ONLY if you choose the Regular Maximum Option or Option 1. 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 8-04A
R032016

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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

Please be sure to 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*.

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

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

Mailing Address | City | State | Zip Code

Signature of Personnel Officer | Date | Daytime Area Code/Phone Number

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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 will result in delays to your patient.** Return the completed form to LASERS at the above mailing address. 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 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**

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