



LOUISIANA SCHOOL EMPLOYEES'  
 RETIREMENT SYSTEM

## Application for Service Retirement, IBRP, or DROP

We suggest you obtain a retirement benefit estimate prior to completing this form. All required documents must be submitted with this completed application. This application may be canceled unless your benefit has been deposited into your account or your check has been cashed.

### Section 1 - Retirement Plan and Effective Date (MM/DD/YYYY)

The effective date cannot be beyond six months from today. If your death occurs within 30 days from the effective date, your application is void.

**Check one:**

- Service (10) Date:  (complete page 1, and attach [Form 8](#) and [Form W4P](#))
- IBRP (10I) Date:  (complete page 1 and 2, and attach [Form 8](#) and [Form W4P](#))
- DROP (10D) Date:  (complete page 1 and 2, participation period up to 36 months)

### Section 2 - Member Information

Last Name	First Name	MI	Jr., III, etc.	Social Security Number - attach copy of card
Address (Street/P.O. Box)				Primary Telephone Number (with area code)
City, State, and Zip Code				Secondary Telephone Number (with area code)
Date of Birth (MM/DD/YYYY) - attach proof of birth				Job Title
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Legally Married <input type="checkbox"/> *Divorced <input type="checkbox"/> *Widowed <i>*Attach divorce documents and/or death certificate</i>				
Spouse's Name: Last, First, MI, Suffix (Jr. III, etc.)		Spouse's Social Security # - attach copy of card		Spouse's Date of Birth (MM/DD/YYYY) - attach proof of birth

### Section 3 - Self-Funded COLA Plan (Optional)

This plan provides a reduced monthly benefit (approximately 20%) in exchange for a 2.5% guaranteed benefit increase every year beginning one year after retirement and age 55; you will also be entitled to any future COLA granted by LSERS' Board of Trustees. This option is irrevocable.

- Yes, I wish to receive a retirement benefit estimate of my benefits if I select the Self-Funded COLA (Cost-of-Living-Adjustments) Plan.

### Section 4 - Retirement Plan Beneficiary (receive a monthly lifetime benefit after your death)

Last Name	First Name	MI	Jr., III, etc.	Social Security Number - attach copy of card
Address (Street/P.O. Box)				Primary Telephone Number (with area code)
City, State, and Zip Code				Date of Birth (MM/DD/YYYY)
Relationship to member		If you want to designate a specific monthly amount for your beneficiary to receive after your death, enter that amount here:		Option 4 and 4A amount \$ <input type="text"/>

Submit [Form 3](#) if you desire to add or update any beneficiaries for receiving any remaining contributions if both you and your plan beneficiary die before the total of benefits paid out is less than your contributions to LSERS.

### Section 5 - Signature of Applicant

I hereby make application for retirement or to enter DROP in accordance with Louisiana laws. I have carefully read the instructions and made the appropriate beneficiary designation(s).

Signature of Member (Do not print or type)	Date Signed (MM/DD/YYYY)
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Forms mentioned throughout this application are located at [www.lasers.net](http://www.lasers.net) > Resources > [Forms](#). For more information on retirement, please refer to [Fact Sheet 12](#) located at [www.lasers.net](http://www.lasers.net) > Resources > Publications > [Fact Sheets](#).

**Page 2 is required for completion if you choose IBRP or DROP retirement plan in section 1.**

Member Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Section 6 - Election to Retire under the IBRP and Selection of Initial Benefit Amount**

**Check one:**

- I want to receive the largest initial benefit allowable and understand that my lifetime monthly benefit will be reduced based on that amount.
- I want to receive an initial benefit in the amount of \$ \_\_\_\_\_ and understand that my lifetime monthly benefit will be reduced based on that amount.

**Section 7 - DROP/IBRP Account Beneficiary(ies)**

Section 7 - DROP/IBRP Account Beneficiary(ies)				
Last Name	First Name	MI	Jr., III, etc.	Social Security Number - attach copy of card
<b>1</b>				
Address (Street/P.O. Box)			Primary Telephone Number (with area code)	
City, State, and Zip Code			Secondary Telephone Number (with area code)	
Date of Birth (MM/DD/YYYY)	Beneficiary Type	Relationship to Member		Percentage of funds
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			%
Last Name	First Name	MI	Jr., III, etc.	Social Security Number - attach copy of card
<b>2</b>				
Address (Street/P.O. Box)			Primary Telephone Number (with area code)	
City, State, and Zip Code			Secondary Telephone Number (with area code)	
Date of Birth (MM/DD/YYYY)	Beneficiary Type	Relationship to Member		Percentage of funds
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			%
Last Name	First Name	MI	Jr., III, etc.	Social Security Number - attach copy of card
<b>3</b>				
Address (Street/P.O. Box)			Primary Telephone Number (with area code)	
City, State, and Zip Code			Secondary Telephone Number (with area code)	
Date of Birth (MM/DD/YYYY)	Beneficiary Type	Relationship to Member		Percentage of funds
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			%

**Section 8 - Waiver of Rights and Signature of Applicant**

I understand that 100% of my balance will be transferred into the default Custom Stable Value (CSV) option in the Self-Directed Plan (SDP) at such time as either my DROP participation period has ended, or my IBRP funds have been finalized.

I understand that I will be subject to the possibility of loss of value should I allocate any portion of my funds to an option other than the CSV option in the SDP.

I understand that any benefits payable from the SDP are not the obligation of the State of Louisiana or the Louisiana School Employees' Retirement System (LSERS).

I understand that any investment returns are the sole responsibility of me and the provider to whom funds have been transferred pursuant to my instruction, and that any violations of the IRS Code occurring as a result of my participation in the SDP are the responsibility of me and the designated provider and not the State of Louisiana or LSERS.

I understand that there will be no liability or cause of action against the LSERS, its agents, or employees for any choices I make in relation to any funds transferred into the SDP.

I understand that my decision is irrevocable.

By my signature below, I understand and agree to the above description regarding my DROP/IBRP funds.

Signature of Member (Do not print or type)	Date Signed (MM/DD/YYYY)
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