LSERS
LOUISIANA SCHOOL EMPLOYEES' RETIREMENT SYSTEM

8660 United Plaza Blvd. (70809) • P.O. Box 44516 • Baton Rouge, Louisiana 70804-4516
Phone: 225.925.6484 • Toll-free: 1.800.256.3718 • Fax: 225.922.1001 • www.lsers.net

14-12
Form 12
6/17

Print Reset

Application for Disability Retirement

In addition to this application, the applicant must furnish a completed Form 12C - Physician Report of Disability, Form 12B - Supervisor Report of Disability, a copy of the official job description, and copies of all legible medical records that support this claim. If approved, the effective date of retirement will be the date the completed application is received in this office or the day after the applicant's last day of employment. It is the applicant's responsibility for all associated costs and to ensure all requirements are met.

Section 1 - Member Information

Last Name	First Name	MI	Suffix	Social Security Number - attach copy of card

Address (Street/P. O. Box) | Primary Telephone Number

City, State, and Zip Code | Secondary Telephone Number

Your Date of Birth - attach proof of birth date
Enter as MM/DD/YYYY / / | Job Title

Marital Status - Check one: *Attach documents
☐ Never Married ☐ Legally Married ☐ *Divorced ☐ *Widowed | Spouse's Social Security # - attach copy of card

Spouse's Name: Last, First, MI, Suffix (Jr., III, etc.) | Spouse's Date of Birth - attach proof of birth date - Enter as MM/DD/YYYY / /

Section 2 - Member Statement

1. When did your disability begin? Enter as MM/DD/YYYY / /
2. Were you treated for this condition prior to your employment with your current employer? ☐ Yes ☐ No
3. Mark the area of specialty of the physician who will complete the Form 12C. Mark only one box.
   ☐ Internal Medicine ☐ Neurology ☐ Orthopedics ☐ Cardiology ☐ Oncology ☐ Psychiatry
4. Are you now or have you ever received Workers' Compensation while a member of LSERS?
   If yes, provide a statement of income from your workers' compensation carrier to include date of award. ☐ Yes ☐ No
5. Are you self-employed or have a job other than the job for which this disability claim is made?
   If yes, provide a statement of income from your self-employment earnings or from your employer. ☐ Yes ☐ No

Section 3 - Beneficiary for Optional Benefit (if member on/after 7/1/2010)

1

Name: Last, First, MI, Suffix (Jr., III, etc.) | Social Security Number

Address (Street/P. O. Box) | Relationship

City, State, and Zip Code | Date of Birth MM/DD/YYYY / / | Sex ☐ Male ☐ Female | Percent Split %

2

Name: Last, First, MI, Suffix (Jr., III, etc.) | Social Security Number

Address (Street/P. O. Box) | Relationship

City, State, and Zip Code | Date of Birth MM/DD/YYYY / / | Sex ☐ Male ☐ Female | Percent Split %

Section 4 - Member Statement

I understand this application is made per R.S. 11:218 and that my medical information will be furnished to the State Medical Disability Board (SMDB) for review and that further medical examinations may be necessary. I also understand that disability benefits are not guaranteed but determined based on the content of this application and related medical information.

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