

Louisiana Sheriffs' Pension & Relief Fund

1225 Nicholson Drive • Baton Rouge, Louisiana 70802
Phone: (225) 219-0500 • (800) 586-9049 • FAX: (225) 219-0521
www.lsprf.com



Dear Applicant:

We have been advised that you wish to apply for disability benefits from the Sheriffs Pension Fund. We will be happy to assist you in any manner possible. The law governing applications for disability retirement requires completion of the enclosed forms as follows as well as information requested in (4) and (5) below:

- (1) Application for Disability Benefits
- (2) Disability Report by Immediate Supervisor
- (3) Medical Authorization and Waiver
- (4) Copy of accident/incident report, if applying for job-related disability
- (5) All pertinent information which your personal physician (s) can provide relative to your case history, including items which would be helpful in substantiating your claim. (such as copies of test, evaluations, hospital records)

Please return the enclosed forms to our office as soon as possible along with the medical records requested in (5) above. Disability applicants will be examined by the State medical Board Physician whose expertise most closely relates to the disability claimed. Therefore, after we receive the information requested, we will call you to set up an appointment with the State Medical Board Physician.

If you have any questions concerning the disability application process or need additional assistance, please let me know.

Sincerely,

Osey "Skip" McGee, Jr.
Executive Director

Serving Those Who Serve

REQUEST FOR INFORMATION

In response to your request for a computation of your pension benefit the following information is required:

Name: _____

Social Security Number: _____

Spouse's Name: _____

Spouse's Social Security Number: _____

Mailing Address: _____

Home Telephone Number: _____

- COPIES OF BIRTH CERTIFICATES OR BAPTISMAL CERTIFICATES FOR YOURSELF & SPOUSE
- COPY OF MARRIAGE CERTIFICATE
- COPY OF DEATH CERTIFICATE OF SPOUSE, IF APPLICABLE
- IF THE EVENT OF A PRIOR MARRIAGE, PLEASE PROVIDE THE FOLLOWING:
 - COPY OF PETITION FOR DIVORCE
 - COPY OF FINAL DIVORCE DECREE
 - COPY OF PROPERTY SETTLEMENT

The following forms are to be completed and returned to our office along with the above information:

- APPLICATION FOR TYPE OF BENEFIT REQUESTED (i.e., retirement, survivor, or disability)
- SUPPLEMENTAL QUARTERLY REPORT
- NOTICE OF TERMINATION / CHANGE OF STATUS

When we receive this information we will compute your retirement benefit under each option. We normally compute the Maximum Option and Option One for unmarried pension applicants. In addition to the Maximum and Option One, we compute Options Two, Two-A, Three, Three-A and Five for married applicants.

There is another option available for all applicants that would provide a monthly benefit to an eligible beneficiary. If you would like more information on this option, please contact the Pension Fund Office.

We will send you a letter outlining your monthly benefit under each option and a copy of the option forms. At that time you will select one option and your beneficiary. Once you have made the option and beneficiary choice, the law does not allow you to change either the option or your beneficiary.

Please feel free to call on us if you have any questions concerning your future retirement.

NOTICE OF TERMINATION/CHANGE OF STATUS

EMPLOYEE NAME _____
HOME ADDRESS (STREET/P.O. BOX) _____
CITY, STATE & ZIP CODE _____
HOME TELEPHONE NUMBER _____
SOCIAL SECURITY NUMBER _____
PARISH OF EMPLOYMENT _____
DATE CONTINUOUS SERVICE BEGAN _____
LAST DATE OF EMPLOYMENT _____

INDICATE YOUR PREFERENCE CONCERNING YOUR FUNDS ON DEPOSIT IN THE SHERIFFS' PENSION FUND.

_____ **I wish to leave my funds on deposit:**

_____ Due to change in status to Part-time.

_____ Due to call to Active Military Duty.

_____ For possible later employment. If termination is due to Leave of Absence, expected date of return _____.

_____ For Retirement when I become eligible. Expected date of retirement _____

_____ **I wish to leave my funds on deposit due to transfer of employment from present Parish of _____ to _____ Parish, effective date of _____.**

_____ **I have terminated employment and have no plans to work for another sheriff's office in Louisiana. I wish to apply for a refund of my employee contributions. I understand that a refund automatically cancels all my rights in the fund and forfeits all prior service and military service as well as membership credit for the period refunded. (This form must be completed, signed by the member and submitted with the refund form to be eligible to receive a refund.)**

_____ **I wish to apply for a Direct Rollover of my funds.**

_____ **I wish to make application for Regular Retirement.**

_____ **I wish to make application for Deferred Retirement Option Plan (BACK DROP) Benefits.**

_____ **I wish to make application for Disability Retirement Benefits.**

EMPLOYEE'S SIGNATURE

SHERIFF OR AUTHORIZED REPRESENTATIVE

DATE

MEDICAL AUTHORIZATION & WAIVER

TO: BOARD OF TRUSTEES
SHERIFFS PENSION & RELIEF FUND

By making application for disability benefits from the Sheriffs Pension & Relief Fund, I hereby agree that the Board of Trustees of the Fund, their employees and attorney, are authorized to secure, review and/or examine any and all medical records, including doctors' opinions, relating to the physical and/or mental condition(s) for which I have made application for disability benefits.

I hereby agree to waive any privilege which might otherwise exist relative to such medical information.

Applicant

Sworn and subscribed before me this _____ day of _____,
20_____.

Notary Public

Parish

DISABILITY CLAIM AUTHORIZATION

Name

() _____
Home telephone #

Social Security #

Parish of employment

Date of birth

Date of employment

Home address

Date employment will terminate

City, State, zip code

() _____
Daytime telephone #

I am disabled from further service with the sheriff's office because _____

I hereby authorize the physician(s) named below to make reports in support of this disability claim to the State Medical Disability Board by submitting to the Sheriffs' Pension Fund any documents deemed appropriate.

(1) _____
Name of physician

(3) _____
Name of physician

Field of specialty

Field of specialty

() _____
Office telephone #

() _____
Office telephone #

(2) _____
Name of physician

(4) _____
Name of physician

Field of specialty

Field of specialty

() _____
Office telephone #

() _____
Office telephone #

Signature of applicant

Witness

Date

Witness

DISABILITY REPORT BY IMMEDIATE SUPERVISOR

Applicant's Name

Social Security #

1. Briefly describe disability applicant's duties and responsibilities: _____

2. List any special physical requirements of the position: _____

3. How long has applicant occupied this position: _____

4. Did applicant have any disability upon employment? If so, briefly describe: _____

5. List specific information you have concerning date and cause of the current disability: _____

6. When and how did the disability begin to affect the performance of applicant's duties? _____

7. Briefly describe efforts made to place applicant in a position that could be performed with the stated disability: _____

8. List specific duties under your supervision that applicant can still perform: _____

9. How many days of sick leave have been taken by applicant since date of disability? _____

10. Was this a marked increase in use of sick leave? _____

Signature of immediate supervisor

Date

Print name and title

Parish

APPLICATION FOR DISABILITY BENEFITS

NAME OF APPLICANT _____

PARISH _____

AGE _____ BIRTHDATE _____

DAYTIME PHONE _____

EMPLOYMENT DATE _____

BREAK IN CONTINUOUS SERVICE (If applicable)

LAST DATE OF EMPLOYMENT _____

FROM _____ THROUGH _____

Applicant states that he/she is permanently disabled as a result of injury or illness which occurred during time of employment in the sheriff's office. Applicant understands that this application is to be substantiated by a full and complete written statement of disability by a practicing physician in Louisiana chosen by the applicant and by a member of the State Medical Disability Board whose specialty most closely relates to the nature of the disability claimed.

Applicant requests that disability benefits begin effective _____. It is understood that if applicant becomes employed or is no longer disabled, he/she will notify the Sheriffs Pension Fund immediately in accordance with RS 11:220C and RS 11:2178B(2).

Applicant's salary as deputy sheriff/sheriff for the thirty-six (36) highest successive months of employment during the stated period of employment was as follows: (If an interruption of service occurred, the highest thirty-six (36) successive, joined months of employment are applicable.) Salary for the highest sixty (60) successive or joined months of employment will be needed for those members whose first employment making them eligible for membership in the retirement system began on or after July 1, 2006.

Jan _____ \$ _____	Jan _____ \$ _____	Jan _____ \$ _____	Jan _____ \$ _____
Feb _____ \$ _____	Feb _____ \$ _____	Feb _____ \$ _____	Feb _____ \$ _____
Mar _____ \$ _____	Mar _____ \$ _____	Mar _____ \$ _____	Mar _____ \$ _____
Apr _____ \$ _____	Apr _____ \$ _____	Apr _____ \$ _____	Apr _____ \$ _____
May _____ \$ _____	May _____ \$ _____	May _____ \$ _____	May _____ \$ _____
Jun _____ \$ _____	Jun _____ \$ _____	Jun _____ \$ _____	Jun _____ \$ _____
Jul _____ \$ _____	Jul _____ \$ _____	Jul _____ \$ _____	Jul _____ \$ _____
Aug _____ \$ _____	Aug _____ \$ _____	Aug _____ \$ _____	Aug _____ \$ _____
Sep _____ \$ _____	Sep _____ \$ _____	Sep _____ \$ _____	Sep _____ \$ _____
Oct _____ \$ _____	Oct _____ \$ _____	Oct _____ \$ _____	Oct _____ \$ _____
Nov _____ \$ _____	Nov _____ \$ _____	Nov _____ \$ _____	Nov _____ \$ _____
Dec _____ \$ _____	Dec _____ \$ _____	Dec _____ \$ _____	Dec _____ \$ _____

REQUESTED BY _____
Applicant's Signature

DATE _____

CERTIFIED CORRECT _____
Signature of Sheriff or Authorized Representative

DATE _____

INSURANCE INVOICE

**WITHHOLDING FROM SHERIFFS' PENSION FUND BENEFIT CHECKS
(PLEASE REMIT BY THE 20TH OF THE PREVIOUS MONTH)**

(MONTH, YEAR)

PENSION RECIPIENT	SOCIAL SECURITY NO. (OR MEMBER NO.)	TOTAL PREMIUM	SHERIFF PAYS	TO BE WITHHELD
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

INVOICE PREPARED BY _____ **PARISH _____

***BY SIGNING THIS INVOICE, YOU AUTHORIZE SPF TO WITHHOLD THE SPECIFIED FUNDS FROM THE RECIPIENTS' BENEFIT**

