REQUEST FOR INFORMATION

Please furnish the following information and documents so that we may accurately compute your survivor benefit:

Member's Name: _____

Member's Social Security Number: _____

Survivor's Name: _____

Survivor's Social Security Number: _____

Mailing Address: _____

_____

_____

Daytime Telephone Number: _____

- COPIES OF BIRTH CERTIFICATES FOR MEMBER AND YOURSELF
- COPY OF MARRIAGE CERTIFICATE
- COPY OF DEATH CERTIFICATE
- COPIES OF BIRTH CERTIFICATES AND SOCIAL SECURITY CARDS OF ALL CHILDREN UNDER THE AGE OF 18 OR UNDER AGE 23 IF ENROLLED AT A BOARD-APPROVED SCHOOL, COLLEGE OR UNIVERSITY

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

- APPLICATION FOR SURVIVOR BENEFITS
- SUPPLEMENTAL QUARTERLY REPORT
- INSURANCE INVOICE

When we receive this information we will compute your survivor benefit and advise you of the amount of your monthly benefit.

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

APPLICATION FOR SURVIVOR BENEFITS

NAME OF APPLICANT_____ DATE OF DEATH _____

NAME OF MEMBER_____ PARISH _____

DATE OF EMPLOYMENT _____ DAYTIME PHONE # _____

LAST DATE OF EMPLOYMENT _____ BREAK IN CONTINUOUS SERVICE (If applicable)

FROM_____ THRU _____

Applicant is eligible for survivor benefits and requests that benefits begin effective_____.
Applicant was married to member on _____, and was married to and living with member on the date of death. Their dependent children are listed below:

NAME	DATE OF BIRTH	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Member's salary as deputy sheriff/sheriff for the thirty–six (36) highest successive months of employment prior to the date of death 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. If member was not employed for a full 36 months prior to date of death, list the salary received during employment.

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 _____ DATE_____
Applicant's Signature

CERTIFIED CORRECT _____ DATE_____
Signature of Sheriff or Authorized Representative

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**

SHERIFFS' PENSION & RELIEF FUND

SUPPLEMENTAL REPORT

REPORT OF WAGES/CONTRIBUTIONS FOR THOSE BEING ***REFUNDED OR RETIRING*** BETWEEN REPORTING PERIODS

Parish _____ **QTR / MON Ending Date** _____

SOCIAL SECURITY #	EMPLOYEE NAME	MONTHLY SALARY	WAGES FOR QTR/MONTH	EMPLOYEE CONTRIBUTIONS

TOTAL WAGES $_____

EMPLOYEE CONTRIBUTIONS $_____

EMPLOYER CONTRIBUTIONS $_____

TOTAL CONTRIBUTIONS $_____

NET CONTRIBUTIONS SUBMITTED $_____

CERTIFIED CORRECT _____ DATE _____

SIGNATURE OF SHERIFF OR AUTHORIZED REPRESENTATIVE