Registrars of Voters Employees' Retirement System

KATHY BOURQUE, DIRECTOR

P. O. BOX 1959
GONZALES, LOUISIANA 70707

www.larovers.com

TEL: 800-510-8515
FAX: 225-647-7914

Application for Disability Retirement

Section 1 – Disclaimer

The application for disability must be received by ROVERS prior to termination of employment unless compelling evidence is presented to prove that the disability occurred while you were an active, contributing member of ROVERS. Submission of an incomplete application could result in a delay or denial of your request to receive benefits. A minimum of 10 years of service credit in ROVERS is required to be eligible for a disability benefit. Once all requested information is received by ROVERS, along with a completed application, an appointment may be made for you to be examined by a board designated physician for determination of whether or not you qualify for a disability benefit.

Section 2 – Member Information

Last Name	First Name	MI	Suffix	Social Security Number – attach a copy of card
Date of Birth (MM/DD/YYYY) – attach copy of birth certificate / /		Sex ☐ Male ☐ Female		Employer/ Parish
Street Address/ P.O. Box				Cell Phone Number
City	State	Zip Code		Work Phone Number
State Personnel Number	E-mail Address			Requested Date of Retirement
Check one: *attach documents (such as Marriage or Death Certificates, Judgments of Divorce) ☐ Never Married ☐ Legally Married* ☐ Divorced* ☐ Widowed*				Spouse's Date of Birth (MM/DD/YYYY) – attach a copy of birth certificate / /
Spouse's Name: Last Name, First Name, MI, Suffix		Spouse's Sex ☐ Male ☐ Female		Spouse's SSN – attach copy of card

Section 3 – Disability Claim Information

Did this disability occur while an active contributing member of ROVERS? ☐ Yes ☐ No

Is this disability the result of a condition that existed prior to your enrollment in ROVERS? ☐ Yes ☐ No

Explanation of Disability Preventing Applicant From Working (attach additional sheets if needed)

I am disabled from performing my job duties because:

Physician Diagnosing Disability			Specialty	
Street Address/ P.O. Box			Phone Number	
City	State	Zip Code	Date of First Visit	Date of Last Visit

Section 4 – Workers' Compensation Information

Are you now receiving or have you ever received Workers' Compensation while a member of ROVERS*? ☐ Yes ☐ No

If the answer to this question is yes, please provide the information requested below. *attach documentation

Insurance Company	Name of Contact at Insurance Company		Phone Number	
Street Address/ P.O. Box			Frequency of Benefit	Amount of Benefit* $
City	State	Zip Code	Date of Settlement / /	Settlement Amount* $

Page 1 of 2: Member's initials:__________ Spouse's initials: __________ Date:_______________

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Application for Disability Retirement Continued	
Applicant Name	Applicant Social Security Number

Section 5 – Option Selection

Please read the description of each option and choose one. If you are legally married your spouse must sign below.

	Maximum Option – Pays the largest monthly benefit the member is eligible to receive but does not provide for a monthly benefit to be paid to a named beneficiary after the member's death. All benefits cease upon the death of the member.
	Option #2 – Upon member's death, his/her reduced retirement allowance shall be paid to, and continued throughout the life of, the member's spouse to whom he/she is married at the time of retirement.
	Option #3 – Upon member's death, one-half of his/her reduced retirement allowance shall be paid to, and continued throughout the life of, the member's spouse to whom he/she is married at the time of retirement.

Section 6 – Affidavit – To Be Completed and Signed Before A Notary

Before me, the undersigned, personally came and appeared, ______________________________ who upon being first duly sworn, made oath that the statements above and below are true. The undersigned applicant did depose and state that he/she provided all medical records related to his/her claimed disability as well as any pre-existing conditions he/she has, whether or not disclosed on this application.

Applicant Request for Benefit and Signature:

I hereby request a benefit in the form shown above. I understand that if my application is approved by the Board and I begin receiving disability benefits, I will be required to submit an annual earnings statement each year by May 1. I understand any outside earnings including worker's compensation, when added to my disability benefit, cannot exceed 100% of my average final compensation. I understand that should my earnings exceed my average final compensation, my disability benefit will be reduced. I understand that for the continuation of disability benefits, I must undergo a medical exam, at my expense, once a year during the first five years following retirement and once in every three-year period thereafter. By making application for disability benefits from the Registrars of Voters Employees' Retirement System, I hereby agree that the Board of Trustees of ROVERS, 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.

____

Signature of Applicant

Legal Spouse Form of Benefit Approval and Signature:

I am legally married to the applicant and hereby consent to the form of benefit selected above. I understand that if the Maximum option is selected, I will not receive a monthly benefit after the death of my spouse.

____

Signature of Applicant's Legal Spouse (if Married)

Sworn to and subscribed before me, NOTARY PUBLIC the above named __________________________ and
Print Applicant's Name

________________________________ in and for the State of Louisiana, Parish of ____________________
Print Name of Applicant's Legal Spouse (if Married) — Parish

on this _____ day of ___________, year of ________.
Day — Month — Year

SEAL

____
Signature of Notary Public

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Disability Report By Employer

Section 1 – Disclaimer

Print or type all entries except for signatures. This section must be completed by the Registrar*. A copy of the applicant's official job description must be attached to this application. All responses to information requested should be complete and made to the best of your knowledge and ability. If additional space is required, please attach additional sheets.

Section 2 – Applicant Information

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

Title of Applicant's Position

Section 3 – Disability Claim Information

1. Do you have any specific knowledge of the cause if the disabling condition? ☐ Yes ☐ No If yes, please describe below.

2. In your opinion, when did the disabling condition begin to affect the applicant's performance of job duties? (Enter as MM/DD/YYYY)
 / /

3. Specifically list the duties stated in the attached official job description that the applicant can no longer perform because of the disabling condition

4. Specifically list duties under your supervision that the applicant can still perform.

5. Describe efforts made by your office to place this applicant in another position.

6. Did this applicant have any physical or medical handicap upon employment? ☐ Yes ☐ No If yes, please briefly describe each below.

7. How many days of sick leave has this applicant taken since the onset of this disabling condition? (Enter as MM/DD/YYYY)
 / /

8. Was this an increase in the use of sick leave? ☐ Yes ☐ No If yes, please explain.

9. Is this applicant currently receiving, or has he/ she previously received, Worker's Compensation benefits? ☐ Yes ☐ No
 If yes, are they receiving this benefit due to the disabling condition? ☐ Yes ☐ No

Section 4 – Signature of Registrar*

Name of Registrar* (Print or Type)

Signature of Registrar* (Do not print or type)	Date Signed (Enter as MM/DD/YYYY)
▶	

* If the applicant is the Registrar, this form should be completed by the Chief Deputy.

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Attending Physician's Statement for Disability Retirement

Section 1 – Disclaimer

To the ATTENDING PHYSICIAN - Please attach all medical records, treatment notes, X-rays, and test results. Failure to do so may result in delays to your patient. 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. If additional space is required, please attach additional sheets.

Section 2 – Applicant Information

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

Section 3 – Disability Claim Information

1. Did the disability occur during employment? ☐ Yes ☐ No

2. Explain in sufficient detail the extent that the patient's illness or injury affects their capacity to perform current job duties as described in the Disability Report by Employer:

3. Primary Diagnosis__________________________________ Secondary Diagnosis________________________________

4. List detailed subjective symptoms. If needed, please attach additional sheets with "subjective symptoms".

5. Date of first visit for this illness/injury__________________________ Date of last visit__________________________

Frequency of current visits: Weekly________ Monthly ____________ Other________________

6. In my opinion, this employee is totally incapacitated from performance of his/her normal job duties. ☐ Yes ☐ No

7. In my opinion, this employee should be retired on disability retirement. ☐ Yes ☐ No

Section 4 – Signature of Physician

Physician's name (Print or Type)	Title or Specialty
Mailing Address	E-mail Address
City, State Zip	Telephone Number
Signature of Physician (Do not print or type) ▶	Date Signed (Enter as MM/DD/YYYY)