Registrar of Voters Employees' Retirement System

Lorraine C Dees, Director

PO Box 57 Jennings, La 70546

Telephone: 1 800 510 8515 Facsimile: 1 337 824 9187 EMAIL: r_rovers@bellsouth.net

APPLICATION FOR RETIREMENT

( ) Service Retirement Allowance
( ) Disability Retirement Allowance
( ) Other (Specify-PostDROP)

Name: ____Parish: (_____) _____________________________
SSN: _______/_______/________ State Personnel # __________________ Date of Birth: _______________
Last day of Employment: ___________________________Date of Retirement: ___________________________
Member's Mailing Address: ____
____
Home Telephone # ( ) _________________________ Cell Telephone # ( ) _____________________

Have you participated in DROP? ( ) Yes ( ) No If yes, when did you complete DROP ____________

************************BENEFICIARY INFORMATION****************

If you would like a benefit calculated other than MAXIMUM, please fill in the beneficiary information requested below.

1. If you have participated in DROP, you may select a different beneficiary on a Post-DROP calculation.
2. If multiple beneficiaries are used, list additional information on the back of this sheet.
3. Please forward copies of SS Cards for EACH beneficiary.
4. if you name a child, a copy of the birth certificate is needed, along with a copy of the child's Social Security Card

Name of Beneficiary: ____

Beneficiary SSN: ____

Beneficiary DOB: ____

Relationship to Retiree: ____

____ ___________________________________
Signature of Retiree Date of Signature

Upon completion of this form, please return it to the R.O.V.E.R.S. office
at least 30 days in advance of your retirement date.

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Retiree and Spouse Information for Insurance and Federal Income Tax

NAME OF RETIREE: ______________________________________

NAME OF SPOUSE: ______________________________________

DATE OF RETIREMENT: __________________________________

DATE FILLED IN: ________________________________

I PRESENTLY HAVE AND WISH TO RETAIN MY INSURANCE WITH THE State of Louisiana. ROVERS is only allowed to withhold premiums for Health and Life Insurance.

_______ Health Insurance
_______ Life Insurance
_______ Dental Insurance
_______ Other Insurance (Specify___________________)

****
_______ My spouse is on my state health insurance policy.
_______ My spouse is NOT on my health insurance policy

****

________ I am over 65
________ I am not over 65

****

________ I am enclosing a completed W-4 Federal Income Tax withholding form

You are not obligated to pay state income tax on your retirement, therefore no state income tax form is needed.

____ ____
Name of Retiree (Print) Signature of Retiree

____ ____
Address of Retiree City/State/ Zip code of Retiree

____ ____
Social Security # of Retiree Date of Retirement

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FOR ROVERS OFFICE USE ONLY

NAME OF EMPLOYEE: ____

Date Application Received: ________________________

Date of Birth: ________________________
AGE: ________________________

BENEFICIARY DOB ________________________
Beneficiary AGE: ________________________

Date of Employment: ________________________
# of years of service ________________________
Accrual Rate: ________________________
Total % to calculate: ________________________

Additional time allowed: ________________________

Reciprocal Recognition of Service: ________________________

Military Service Credit ________________________

Actuarial Transfer of Service: ________________________
Actuarial Transfer Accrual: ________________________

Unused Leave Time ________________ Annual
________________ Sick

Date/Amount of First Check ________________________
$________________________

Original Pension Amount: $ ________________________

Approved by _______________Director Date____________