

**District Attorneys' Retirement System
RETIREMENT APPLICATION CHECKLIST**

This form should be returned with the completed original application for retirement.

Name: _____

General Information:

Verify Member DOB
Verify Beneficiary DOB
Verify Social Security Number for Member and Beneficiary (if applicable)
Personal contact information used, NOT office contact information.
Include an email address for future notifications
Confirm application is properly notarized

Date of Retirement and Last Day of Active Service

Confirm that date of retirement and last day of active service are NOT the same

Please include a copy of the following:

Driver's License or other Government Issued Identification
Oath or Commission
Beneficiary's Driver's License or other Government Issued Identification
Community Property judgment or separate property agreement if divorced during your service
Certification of Termination Form Signed by Employer
W4-P (even if no taxes withheld)
Electronic Deposit Form

Post Retirement Re-employment Acknowledgment

By my signature on the enclosed application for retirement I hereby acknowledge that I am aware that if I am reemployed as an employee by any district attorney in the state, my retirement benefit shall be suspended during said employment, and I shall not be paid any benefits for the period covered by such employment unless I meet exception requirements of R.S. 11:1631(F)(2). I further acknowledge and consent that any DARS benefits paid in violation of R.S. 11:1631(F)(1) will be recaptured by DARS prior to payment of any benefits due.

Initial Benefit Payment(s) Acknowledgment

I understand and acknowledge that I will be paid 75% of an estimated benefit until confirmed by the actuary which while unlikely, could take 4-6 months. Further, I understand that interest shall not accrue during the confirmation period.

I understand and acknowledge that if I choose BackDROP, funds will not be available until confirmed by the actuary which while unlikely, could take 4-6 months. Further, I understand that interest shall not accrue during the confirmation period.

Member Signature: _____ Date: _____

Mail all paperwork to:

**District Attorneys' Retirement System
2525 Quail Drive
Baton Rouge, LA 70808**

**Louisiana District Attorneys' Retirement System
Application for Retirement/Back-Deferred Retirement Option Plan (Back-DROP)**

Member Information

Name:		Social Security Number:	
Home Address:		Gender:	Male Female
City:	State:	Zip:	Date of Birth:
Home Phone:	Cell Phone:	Email Address:	
Office/Parish Last Employed:		Marital Status:	Single Married Divorced*
Effective Date of Retirement:		Last Date of Active Service: (Last date on payroll)	

Selection of Benefit (Choose One)

<input type="checkbox"/>	Regular Retirement (No Lump Sum)	<input type="checkbox"/>	Back-DROP Benefit
<input type="checkbox"/>	Early Retirement (No Lump Sum)	Number of Months of Back-DROP _____	

Selection of Retirement Option (Choose One)

<input type="checkbox"/>	Maximum Plan—Maximum allowance payable during life but does not provide for a monthly benefit to be paid to a named beneficiary after the retiree's death.
<input type="checkbox"/>	Option 1—Reduced allowance payable throughout life with the provision that if the retiree dies before he has received in annuity payments the value of the participant's annuity as it was at the time of his retirement, the balance shall be paid to his legal representatives or to such person as he shall nominate by written designation duly acknowledged and filed with the Board.
<input type="checkbox"/>	Option 2—Reduced allowance payable throughout life with the provision that upon death of the retiree, the reduced retirement allowance shall be continued throughout the life of and paid to such person as he shall have nominated by written designation duly acknowledged and filed with the Board of Trustees at the time of his retirement.
<input type="checkbox"/>	Option 3—Reduced allowance payable throughout life with the provision that upon death of the retiree, one-half of the reduced retirement shall be continued throughout the life of and paid to such person as he shall have nominated by written destination duly acknowledged and filed with the Board of Trustees at the time of his retirement.
<input type="checkbox"/>	Option 4—Reduced allowance payable throughout life with the provision that some other benefit or benefits shall be paid either to the participant or to such person or persons as he shall have nominated provided such other benefit or benefits, together with the reduced retirement allowance, shall be certified by the actuary to be equivalent actuarial value to his retirement allowance and approved by the Board. Requested Monthly Beneficiary Amount: \$ _____

No optional selection shall be effective if a retiree dies within thirty days after retirement, in such instance a retiree shall be considered as an active member at the time of death (see R.S. 11:1637).

Spousal Consent Affidavit (Notary Required)

State of Louisiana, Parish of _____, On this _____ day of _____, 20____, personally came and appeared _____, who after being duly sworn did depose and state as follows:
I acknowledge that I am fully aware that my spouse, _____, has chosen the following retirement option through the District Attorneys' Retirement System (check one):

<input type="checkbox"/>	The maximum benefit allowance
<input type="checkbox"/>	Retirement Benefit Option No. _____. I have read the above option, and I fully understand it.

This election is made with my full knowledge and consent.

Affiant's Signature: _____ Affiant's Social Security Number: _____

Notary Public: _____ Notary ID #: _____

Notary Public Printed Name: _____

Beneficiary Information

I hereby designate the below named person as my beneficiary to receive benefits as chosen in the SELECTION OF RETIREMENT PLAN OPTION section above. I understand that I cannot change the option beneficiary or the option selected after the effective date of retirement.

Name:		Social Security Number:	
Home Address:		Gender:	Male Female
City:	State:	Zip:	Date of Birth:
Home Phone:	Cell Phone:	Email Address:	
Relationship to Member:		Spouse <input type="checkbox"/>	Child <input type="checkbox"/> Other <input type="checkbox"/>

Back-DROP Beneficiary Information

I hereby designate the below named person as my beneficiary to receive a refund of my Back-DROP lump sum if I die prior to payment of the lump sum amount. I understand that if I do not specify a beneficiary for this purpose, the beneficiary listed above in the Spousal/Beneficiary Information section will be deemed the beneficiary for this purpose also.

Name:		Social Security Number:	
Home Address:		Gender:	Male Female
City:	State:	Zip:	Date of Birth:
Home Phone:	Cell Phone:	Email Address:	
Relationship to Member:		Spouse <input type="checkbox"/>	Child <input type="checkbox"/> Other <input type="checkbox"/>

Reemployment Restrictions

By my signature on this application for retirement I hereby acknowledge that I am aware that if I am reemployed as an employee by any district attorney in the state, my retirement benefit shall be suspended during said employment, and I shall not be paid any benefits for the period covered by such employment unless I meet the exception requirements of R.S. 11:1631(F)(2). I further acknowledge and consent that any DARS benefits paid in violation of R.S. 11:1631(F)(1) are subject to recapture by DARS prior to payment of any benefits due.

Member Signature (Notary Required)

State of Louisiana, Parish of _____, On this _____ day of _____, 20____,

personally came and appeared _____, who made oath that the statements made above are true.

Signature of Applicant: _____

Notary Public: _____ Notary ID #: _____

Notary Public Printed Name: _____

Please attach a copy of the applicant's current driver's license or other form of valid government identification.

***A copy of your community property settlement addressing your DARS retirement benefit is required for divorced applicants.**

Certificate of Eligibility (to be completed by DARS)

Date Application received _____

Approved by Board of Trustees _____

Amount of \$ _____ \$ _____

 No Option Option # ___

Amount of \$ _____ \$ _____

 No Option Option # ___

District Attorneys' Retirement System

EMPLOYMENT TERMINATION CERTIFICATION

(To Be Completed By Employer)

Member:

DA's Office:

Current Date:

EMPLOYMENT INFORMATION

Start Date:

Termination Date (final day working or on paid leave):

Final Paycheck Date:

Final Annual Salary From All Sources of Pay:

Child Support/IVD Employee?

_____ Yes _____ No

Any Known Dates of Leave Without Pay:

Employer Signature: _____

DISTRICT ATTORNEYS' RETIREMENT SYSTEM

2525 Quail Drive
Baton Rouge, LA 70808
Telephone (225) 267-4824 Fax (225) 612-7117

**APPLICATION/AUTHORIZATION FOR ELECTRONIC DEPOSIT
OF RETIREMENT BENEFITS**

I hereby authorize the District Attorneys' Retirement System, hereinafter called **THE SYSTEM**, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error in my account (select one)

Checking

Savings

indicated below and the depository (bank) named below, hereinafter called **DEPOSITORY**, to credit and/or debit the same to such account.

DEPOSITORY (BANK) NAME: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BANK TRANSIT/ABA #: _____ MY ACCOUNT #: _____

This authority is to remain in full force and effect until **THE SYSTEM** has received written notification from me of its termination I such time and in such a manner as to afford **THE SYSTEM** and the **DEPOSITORY** a reasonable opportunity to act on it.

NAME: _____ SOCIAL SECURITY #: _____
(Please Print)

SIGNATURE: _____ DATE: _____

CONTACT NUMBERS (RES): _____ (RELATIVE) _____

VERY IMPORTANT!!

***** (ATTACH CHECK OR DEPOSIT SLIP HERE) *****

IN ORDER FOR THIS APPLICATION TO BE ACCEPTED AND TO CONFIRM ACCOUNT NUMBERS, IT IS NECESSARY THAT WE HAVE THE FOLLOWING:

FOR CHECKING – A “VOIDED” CHECK FROM YOUR PERSONAL CHECKBOOK WHICH MUST INCLUDE YOUR **PREPRINTED** PERSONAL INFORMATION, I.E. ACCOUNT NAME, ADDRESS, ETC.

FOR SAVINGS – A “DEPOSIT SLIP” WITH **PREPRINTED** ACCOUNT INFORMATION.

*****NECESSITY*****

A **POWER-OF-ATTORNEY** IS REQUIRED ON ACCOUNTS WITH SIGNEES OTHER THAN THE MEMBER AND HIS/HER SPOUSE (Please send with this application. These forms will be provided for your convenience upon request).