Louisiana Clerks of Court Retirement and Relief Fund
10202 Jefferson Highway ● Building A ● Baton Rouge, Louisiana 70809
Phone: (800) 256-6660 ● Phone: (225) 293-1162 ● Fax: (225) 291-7859

APPLICATION FOR RETIREMENT/DROP/POST DROP

Name:			
Address:		Sex: ☐ Female ☐ Male	
City:		Social Security #:	
State:	Zip Code:	Employer Parish:	
Home Number:		Date of Birth:	
Work Number:		Date of Employment:	
Cell Number:		Date of Last Active Payroll: *(Retiring Only)*	
Email Address:		Date of Retirement:	
Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Widowed		Total Service Credit:	

SELECTION OF BENEFIT *(Choose One)*

☐ **Regular Retirement**

☐ **Post DROP Retirement**
(Only after completion of DROP)

☐ **DROP**
Date of Participation in DROP begins: _____

Length of Participation: _____
(Not to exceed 36 months)

SELECTION OF RETIREMENT/DROP/POST DROP OPTIONS *(Choose One)*

☐ **MAXIMUM PLAN** - pays the largest monthly benefit allowable to the retiree, but makes no provision for a beneficiary. Under this plan, all benefits cease upon the death of the retiree, unless benefits paid to the member prior to death are less than the contributions made by the member prior to retirement. **I hereby apply for retirement under the Maximum plan.** ***(If married, a spouse must complete the spousal consent section below)***

☐ **OPTION NO. 1** - if the retiree dies before he/she has received, in annuity payments purchased by his/her contributions, the amount his/her contributions accumulated at the time of his/her retirement, the balance thereof shall be paid to any person he/she shall have nominated by written designation, duly acknowledged and filed with the board of trustees at the time of his/her retirement, or, if none, to his/her estate. **I hereby apply for retirement under Option 1.** ***(If married, a spouse must complete the spousal consent section below)***

☐ **OPTION NO. 2** - upon his/her death, the retiree's reduced retirement allowance shall be continued throughout the life of and be paid to any person he/she shall have nominated by written designation, duly acknowledged and filed with the board at the time of his/her retirement. **I hereby apply for retirement under Option 2.** ***(If married and if you have not selected your spouse as the designated beneficiary, then your spouse must complete the spousal consent form below.)***

☐ **OPTION NO. 3** - upon his/her death, one-half (½) of the retiree's reduced retirement allowance shall be continued throughout the life of and be paid to any person he/she shall have nominated by written designation, duly acknowledged and filed with the board at the time of his/her retirement. **I hereby apply for retirement under Option 3.** ***(If married, a spouse must complete the spousal consent form below.)***

☐ **OPTION NO. 4** - other benefit or benefits shall be paid either to the retiree or to the person he/she shall have nominated, provided such other benefit or benefits, together with the reduced retirement allowance, shall be certified by the actuary to be of equivalent actuarial value to the retirement allowance and shall be approved by the board. **I hereby apply for retirement under Option 4. $_____ is designated for my beneficiary at my death.** ***(If married, a spouse must complete the spousal consent section below)***

☐ **OPTION NO. 5** - the retiree may elect to receive ninety percent (90%) of his maximum retirement and upon death, if he/she is survived by a spouse to whom he/she was married at the time of his/her retirement, fifty percent (50%) thereof shall be paid to the surviving spouse during his/her lifetime. **I hereby apply for retirement under Option 5.**

SPOUSAL CONSENT/NOTARY *(If Applicable)* *(Spouse Signature must be Notarized)*

I am legally married to the applicant and I consent to the option selected above.

_____ _____ _____
Signature of Spouse | Printed Name of Spouse | Date

SWORN TO AND SUBSCRIBED BEFORE ME, Notary Public, in and for the state of _____,
Parish of _____, this _____ day of _____, 20 _____.

_____ _____ _____
Notary ID # or Bar Roll # | Notary Public Name (Printed) | Notary Public Name (Signature)

SPOUSAL/BENEFICIARY INFORMATION

I hereby designate my beneficiary under said Option Plan, to receive benefits should I predecease him/her.

Name of Beneficiary:	Sex:
Relationship to Member:	Date of Birth:
Social Security Number:	*Proof of age of beneficiary must accompany this application if an option 2, 3, 4 or 5 is elected.*

IMPORTANT

SIGNATURES OF MEMBER and WITNESSES *(This section must be signed by member and witnesses)*

- Any member may cancel his or her application for retirement prior to the effective date of said retirement; however a member cannot cancel his application for retirement once payment for benefit has commenced.
- Should you become re-employed after your retirement in any capacity in any office of a Clerk of Court, you and the Clerk are required by law to report such re-employment to the retirement office immediately.
- It is the responsibility of the member to submit a Federal Income Tax Withholding Certificate (W4-P) to instruct the retirement office as to whether you do or do not want taxes withheld from your benefit.
- If a retired member dies, without having received an amount of retirement benefits equal to his/her accumulated contributions at the date of his/her retirement, the balance remaining shall be paid to his/her designated beneficiary or, if none, his/her estate.
- No changes in the options elected or the selection of the option beneficiary shall be permitted after the retiree has received his/her initial monthly benefit payment.

Witness

Witness

I have read and understand the above statement and I certify that the information provided herein is true and correct to the best of my knowledge.

Date **Signature of Applicant**

CERTIFICATE OF THE CLERK FOR RETIREMENT

Having read the above application for Service Retirement, I hereby certify that the applicant has notified me of his/her desire to be relieved from active duty as a Clerk of Court, Deputy Clerk of Court, or other employee of my office, and that he/she will or did terminate on the _____ day of _____, 20 _____, at which time his/her salary and or earnings will or did cease.

I, further certify that if the retiree is re-employed in any capacity in my office, I will immediately notify the Board of the dates of re-employment.

Date **Signature of the Clerk of Court**

Parish of : _____

CERTIFICATE OF THE CLERK FOR DROP

Having read the above application for Deferred Retirement Option Plan (DROP), I hereby certify that the applicant is currently employed in my office and employement is expected to continue for the length of participation in DROP indicated in this application.

I have reviewed and certified the above information is correct to the best of my knowledge.

Date **Signature of the Clerk of Court**

Parish of : _____

FOR RETIREMENT OFFICE USE ONLY

Monthly Benefit: _____ Option Benefit to Beneficiary: _____ Date Benefits are to Commence: _____ Date Approved: _____	(Received Stamp)

Forms may be faxed to the office but the original documents are required by mail for the application to be valid. Thank you.

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

OMB No. 1545-0074

2017

Purpose. Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W-4P to choose (a) not to have any federal income tax withheld from the payment (except for eligible rollover distributions or for payments to U.S. citizens to be delivered outside the United States or its possessions) or (b) to have an additional amount of tax withheld.

Your options depend on whether the payment is periodic, nonperiodic, or an eligible rollover distribution, as explained on pages 3 and 4. Your previously filed Form W-4P will remain in effect if you don't file a Form W-4P for 2017.

What do I need to do? Complete lines **A** through **G** of the **Personal Allowances Worksheet.** Use the additional worksheets on page 2 to further adjust your withholding allowances for itemized deductions, adjustments to income, any additional standard deduction, certain credits, or multiple pensions/more-than-one-income situations. If you don't want any federal income tax withheld (see *Purpose*, earlier), you can skip the worksheets and go directly to the Form W-4P below.

Sign this form. Form W-4P **is not** valid unless you sign it.

Future developments. For the latest information about Form W-4P, such as legislation enacted after we release it, go to *www.irs.gov/w4p*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You're single and have only one pension; or
- You're married, have only one pension, and your spouse has no income subject to withholding; or
- Your income from a second pension or a job or your spouse's pension or wages (or the total of all) is $1,500 or less.

. . . . . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you're married and have either a spouse who has income subject to withholding or more than one source of income subject to withholding. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter the number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return . . . . . **E** _____

F **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . . . . **F** _____

G Add lines A through F and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶ **G** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you're **single and have more than one source of income subject to withholding** or are **married and you and your spouse both have income subject to withholding** and your combined income from all sources exceeds $50,000 ($20,000 if married), see the **Multiple Pensions/More-Than-One-Income Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line G on line 2 of Form W-4P below.

---------- **Separate here and give Form W-4P to the payer of your pension or annuity. Keep the top part for your records.** ----------

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

OMB No. 1545-0074

2017

▶ **For Privacy Act and Paperwork Reduction Act Notice, see page 4.**

Your first name and middle initial	Last name	**Your social security number**
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract
City or town, state, and ZIP code		

Complete the following applicable lines.

1 Check here if you **do not want any** federal income tax withheld from your pension or annuity. (Do not complete line 2 or 3.) ▶ ☐

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or annuity payment. (You also may designate an additional dollar amount on line 3.) . . . . . ▶ _____ (Enter number of allowances.)

Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

3 Additional amount, if any, you want withheld from each pension or annuity payment. (**Note:** For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.) . . . . ▶ $

Your signature ▶ **Date ▶**

LOUISIANA CLERKS OF COURT RETIREMENT AND RELIEF FUND
10202 Jefferson Highway • Building A • Baton Rouge, Louisiana 70809
TELEPHONE (225) 293-1162 • (800) 256-6660 • FACSIMILE (225) 291-7859

DIRECT DEPOSIT FORM

I (we) hereby authorize the Louisiana Clerks' Retirement and Relief Fund to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my **(*Select one*)** ☐ **Checking Account** ☐ **Saving Account**, indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

This authority is to remain in effect until the Louisiana Clerks' Retirement and Relief Fund has received **written notification** from me of its termination in such time and manner as to afford the Louisiana Clerks' Retirement and Relief Fund and the Depository a reasonable opportunity to act on it.

Signature of Member: _____

Member's Name: _____ Date: _____
(Please Print Name)

Member's Social Security Number: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name as it appears on the bank account: _____

Depository Name (Bank, Credit Union, etc.): _____

Routing Number: _____

Account Number: _____

PLEASE ATTACH A VOID CHECK WITH THIS APPLICATION

The check must have a 9 digit routing number on it. (bottom left corner)

For Office Use Only

Transit/ABA #: _____ Account #: _____

LOUISIANA CLERKS OF COURT INSURANCE TRUST - RETIREE
GROUP HEALTH, DENTAL, VISION & LIFE INSURANCE ENROLLMENT / CHANGE FORM

Group Health Plan #: ***78C96 ERC***
Group Life Plan #: ***145101***
Group Dental Plan #: ***15663***
Group Vision Plan #: ***160-145101***

LCCIT

OFFICE USE ONLY:

EFF DATE: _____ /_____ /_____

Enrollment: ☐ **Change in Coverage** ☐ **Cancellation** ☐ **Other:**_____

1. NAME (Last, First, Middle Initial)	**2. SOCIAL SECURITY NUMBER** - -
3. MAILING ADDRESS (Street, City, State, Zip Code)	**4. HOME #** ( ) -
	5. ALTERNATE # ( ) -
6. PHYSICAL ADDRESS (Street, City, State, Zip Code)	**7. DATE OF BIRTH** / /
	8. DATE OF RETIREMENT / /
9. PARISH (where you worked)	**10. ARE YOU DISABLED?** ☐ **NO** ☐ **YES** (if yes, you must submit a waiver request for Life)
	11. GENDER ☐ **MALE** ☐ **FEMALE**

12. CHECK COVERAGE(S) SELECTED FOR SELF

☐ **AARP® Medicare Supplement Insurance Plan w/ Aetna Medicare Supplement Rx (PDP)** (additional form must be completed for all Medicare eligible survivors)

☐ **Medical Option 1** ☐ **Medical Option 2** ☐ **Dental** ☐ **Vision** ☐ **Basic Retiree Life**

☐ **Supplemental Life - Select amount** ($4.75 per $1,000 of coverage) ☐ **$5,000** ☐ **$10,000**

13. COMPLETE THE FOLLOWING FOR DEPENDENT COVERAGE **IF CHANGE, EFFECTIVE DATE:** / /

LAST NAME	FIRST NAME	BIRTH DATE	SSN - *Required*	GENDER	Check Coverage Selected					RELATIONSHIP
					AARP	Med 1	Med 2	Dental	Vision	
		/ /	- -	☐ M ☐ F	☐	☐	☐	☐	☐	
		/ /	- -	☐ M ☐ F	☐	☐	☐	☐	☐	
		/ /	- -	☐ M ☐ F	☐	☐	☐	☐	☐	

14. CHANGE IN COVERAGE

☐ **DELETION - REASON FOR CHANGE:** _____

Address to send dependent COBRA Election form for term: _____

15. CHANGE NAME FROM: _____ **TO:**_____

16. CANCELLATION OF COVERAGE(S) *Please submit proper documentation*

☐ **Notice of cancellation of all coverages - effective date:** / /

☐ **I hereby cancel the following coverage(s) only:**_____

Reason for cancellation: _____

RETURN COMPLETED FORMS BY: **EMAIL -** HUNTBENEFITS@WILLIS.COM **FAX -** (850) 893-7245
MAIL - LCCIT C/O HUNT INSURANCE GROUP, LLC, 3606 MACLAY BLVD S, STE. 204, TALLAHASSEE, FL 32312

Revised as of 11/5/14

**** SEE BACK FOR SIGNATURES AND ADDITIONAL INFORMATION ****

LOUISIANA CLERKS OF COURT INSURANCE TRUST - RETIREE
GROUP HEALTH, DENTAL, VISION & LIFE INSURANCE ENROLLMENT / CHANGE FORM

BENEFICIARY (IES) ☐ **CHECK BOX IF CHANGING BENEFICIARY -** *Use additional sheet if necessary*

CLASS	NAME	RELATIONSHIP	PERCENTAGE*
☐ Primary ☐ Contingent	_____	_____	_____%
☐ Primary ☐ Contingent	_____	_____	_____%
☐ Primary ☐ Contingent	_____	_____	_____%
☐ Primary ☐ Contingent	_____	_____	_____%
☐ Primary ☐ Contingent	_____	_____	_____%

***** *If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares. The amounts must add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%."*

EMERGENCY CONTACT: Name: _____

Relationship: _____ Phone #: _____

ARE YOU OR ANY FAMILY MEMBERS COVERED BY ANY OTHER INSURANCE PLAN? ☐ Yes ☐ No

If yes, for what coverage: ☐ Health ☐ Medicare Supplement ☐ Dental ☐ Vision

Please provide existing coverage information below (*use an additional sheet if necessary)*:

Who is covered? _____

Insurance Carrier: _____ Policy #: _____

Effective Date: _____ Term Date: _____

ARE YOU OR YOUR SPOUSE CURRENTLY ON MEDICARE? ☐ Yes ☐ No

If yes, who? ☐ Yourself ☐ Spouse ☐ Both What part? ☐ Part A ☐ Part B ☐ Part A & Part B

Please provide existing coverage information below:

Policy #: _____ Effective Date: _____

Policy #: _____ Effective Date: _____

I hereby certify that this foregoing information is true and correct to the best of my knowledge. I hereby accept the form(s) of group insurance presently contracted for me by my prior employer with the Louisiana Clerks of Court Insurance Trust in the amount(s) for which I am or may become eligible and authorize until revoked by me in writing. I have read the statements on this form.

RETIREE SIGNATURE: _____ DATE: _____/_____/_____

I understand and agree that any misstatement on this form may result in denial of benefits and/or termination of coverage/ membership. I agree to be bound by the group contract's terms and conditions. I understand that this application is here-by made a part of the group contract. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.