



## RETIREMENT/DROP ESTIMATE REQUEST

### MEMBER'S INFORMATION

Name:		Last 4 Digits of SSN:
Mailing Address:		Date of Birth:
City:	State:	Zip Code:
Phone Number:	Email Address:	

Name of Employer:

Please check: ☐ Retirement ☐ DROP ☐ Early ☐ Disability

Date of Retirement/Date of Entry into DROP: \_\_\_\_\_

Effective date of estimate is always the 1st of the month and should be at least 2 months from today's date

Did you participate in DROP? If yes, date DROP participation ended: \_\_\_\_\_

How would you like to receive your estimate? ☐ Mail ☐ Email

Send copy to employer? ☐ Yes ☐ No

Automatic COLA Option Calculation? ☐ Yes ☐ No

If selected, member receives a reduced benefit amount to receive an annual 2.5% COLA each year, beginning at age 55, in addition to any COLAs declared by the Legislature or Board of Trustees, in very limited circumstances.

I have read and understand this *Retirement/DROP Estimate Request*. I have completed this form and certify, that to the best of my knowledge, all information provided is true and correct.

Signature of Member

Date of Signature

Mail completed form to the address below or fax to 225-925-4816 & please allow two to four weeks for your estimate.

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