



REQUEST FOR REFUND OF EMPLOYEE CONTRIBUTIONS BY BENEFICIARY OR PERSONAL REPRESENTATIVE

To the LAGERS Board of Trustees
P.O. Box 1665 Jefferson City, MO 65102
Tel: 800-447-4334 Fax: 573-636-9671

PLEASE PRINT

Full Name of Employee:

LAGERS Employee Number: _____ - ____ - _____

Termination Date: _____

Name of Subdivision:

Employee's Social Security No.: _____

Date of Death (if applicable): _____

Personal Representative _____ Beneficiary _____
(Check **one**)

Name of Applicant: _____

Applicant's Social Security No.: _____

Applicant's Phone No.: _____

Please attach copies of the following:

- A. Certified Copy of Death Certificate
- B. Certified Copy of Court Order (if personal representative)
- C. Proof of Guardianship (if beneficiary is a minor)

I DECLARE THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ Date

_____ Signature of Beneficiary or Personal Representative

REFUNDS WILL NOT BE PAID BEFORE THE EXPIRATION OF 60 DAYS FROM THE DATE OF TERMINATION. IF WAGES WERE REPORTED IN THE MONTH OF TERMINATION, THE REFUND WILL BE PAID APPROXIMATELY 60 TO 90 DAYS FROM THE DATE OF TERMINATION. (Checks are issued on the 1st working day of the month only, but not earlier than 60 to 90 days from the date of termination).

Please send the refund check to:

_____ Full Name

_____ Street Address

_____ City State Zip

Please list permanent address, if different.

_____ Full Name

_____ Street Address

_____ City State Zip