

CITY OF NEW ORLEANS
EMPLOYEES' RETIREMENT SYSTEM
1300 PERDIDO STREET, ROOM 1E12
NEW ORLEANS, LA 70112
(504) 658-1850 FAX (504) 658-1602

DROP CERTIFICATION AT END OF PARTICIPATION/EMPLOYMENT

INSTRUCTIONS: PRINT IN INK OR TYPE ALL ENTRIES EXCEPT SIGNATURES.

Employee: Complete section I; thru IV and forward this form to your employer/appointing authority.

NOTE: If you complete Section IV you must also complete and submit a Deferred Retirement Option Plan Withdrawal Method (RS-11.4) form.

Employer/Appointing Authority: Complete Section V of this form and forward the completed form to the City of New Orleans Employees' Retirement System.

SECTION I - MEMBER INFORMATION

PRINT NAME: LAST FIRST MI SUFFIX (JR., III, ETC.) SOCIAL SECURITY NUMBER

ADDRESS

CITY STATE ZIP ENDING DATE OF DROP PARTICIPATION

DAYTIME PHONE NO. EVENING PHONE NO. MO. DATE YEAR

() ()

SECTION II - CONTINUATION OF EMPLOYMENT

I understand that payments into my DROP account shall cease and no further interest shall be earned or credited to my DROP account, if I elect to continue employment. I understand that payment from the DROP account shall not be process until my employment is terminated; nor shall my monthly benefits be payable until I terminate employment. I also understand that I must resume contributions as a member of the system; I further understand that credit for the additional service shall be paid as a supplement to the original pension amount based on my time worked after DROP Participation.

I elect to continue employment. ()

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____
(DO NOT PRINT OR TYPE) (NO FACSIMILE OR COPIES ACCEPTED)

SECTION III - CONVERSION OF LEAVE TO SUPPLEMENTAL RETIREMENT CREDIT

I request the conversion of my sick and/or annual leave accumulated and not covered prior to DROP and/or accumulated during the DROP participation to supplemental retirement credit.

Number of Sick Leave Hours _____ Number of Annual Leave Hours _____

I understand that the original retirement benefit allowance will not be recalculated and that the supplemental benefit allowance is to be paid in addition to the original regular retirement allowance. Further, I understand the average salary used in the calculation of the supplemental benefit will be based on the salary earned during the DROP period.

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____
(DO NOT PRINT OR TYPE) (NO FACSIMILE OR COPIES ACCEPTED)

SECTION IV – TERMINATION OF EMPLOYMENT

Upon termination I will begin receiving a monthly retirement benefit based upon the retirement option selected at the time I entered the DROP program. **NOTE:** You **must** complete RS-11.4 form regarding the withdrawal method for DROP funds.

DATE OF TERMINATION _____ / _____ / _____

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____
(DO NOT PRINT OR TYPE) (NO FACSIMILE OR COPIES ACCEPTED)

SECTION IV - AGENCY CERTIFICATION

This section of the form must be completed by the employer and signed by the employer's representative whose authorized signature is on file at the City of New Orleans Employees' Retirement System.

I hereby certify that all appropriate offices of this agency have been notified of this DROP participant's intention to either terminate or continue employment as stated above by this employee and that if the employee has elected to continue employment that the appropriate actuarially determined Employer's Contributions must be paid into the Retirement System.

APPOINTING AUTHORITY SIGNATURE _____ DATE SIGNED _____
(DO NOT PRINT OR TYPE) (NO FACSIMILE OR COPIES ACCEPTED)

TITLE _____ DEPARTMENT _____

PLEASE FORWARD THIS FORM TO THE CITY OF NEW ORLEANS EMPLOYEES' RETIREMENT SYSTEM

G:\FIRT\CLERICAL\RETIREFM\RS-11.3 DROP CERTIFICATION AT END.WPD

**CITY OF NEW ORLEANS
EMPLOYEES' RETIREMENT SYSTEM
1300 PERDIDO, ROOM 1E12
NEW ORLEANS, LA 70112
(504) 658-1850 FAX (504) 658-1602**

DROP WITHDRAWAL METHOD SELECTION

INSTRUCTIONS: PRINT IN INK OR TYPE ALL ENTRIES EXCEPT SIGNATURES. Section I and II, as applicable, must be completed by the retiree. This form must be received by the City of New Orleans Employees' Retirement System (NOMERS) at least thirty (30) days prior to completion of participation in the Deferred Retirement Option Plan (DROP) and/or termination of employment. Total DROP account balance distributions may be requested at any time after monthly or annual withdrawals have begun.

SECTION I - I hereby select a method for withdrawal of funds in my DROP account held by the City of New Orleans Employees= Retirement System

RETIREE'S NAME: LAST FIRST MI SUFFIX (Jr., III, etc.) SOCIAL SECURITY NUMBER

DAYTIME PHONE NO () _____ EVENING PHONE NO () _____

MARITAL STATUS: _____ SINGLE _____ MARRIED _____ LEGALLY SEPARATED _____ DIVORCED _____ WIDOWED

HOME ADDRESS: STREET/P. O. BOX

CITY STATE ZIP

WITHDRAWAL SELECTION

NOMERS will distribute DROP fund account funds in accordance with the percentages or dollar amounts selected below. Please complete percentages or dollar amounts. DO NOT USE BOTH.

	PERCENTAGE	DOLLAR AMOUNT
Direct distribution to the member	_____	_____
Rollover into an IRA or Qualified Trust Noted in Section II	_____	_____
Annuity with NOMERS for Distribution over 119 months	_____	_____

The withdrawal of DROP account balances is subject to a mandatory 20% withholding for federal income tax unless the distribution(s) is less than \$200 or is directly rolled over by the City of New Orleans Employees' Retirement System to an Individual Retirement Account (IRA), qualified retirement plan or Annuity.

SECTION II - United States Financial Institution to which rollover(s) will be sent

(ROLLOVER MUST BE EQUAL TO \$200 OR MORE)

NAME AND TITLE OF CONTACT PERSON	ACCOUNT NUMBER
NAME OF FINANCIAL INSTITUTION	TYPE OF PLAN (IRA, etc.)
ADDRESS/P.O. BOX	DAYTIME PHONE NO.
CITY STATE ZIP	() _____

I certify that the information I have entered on this form is true, correct and complete. I have received a copy of the Special Tax Notice from the Employees' Retirement System.

RETIREE'S SIGNATURE _____ DATE SIGNED _____
(DO NOT PRINT OR TYPE)(NO FACSIMILE OR COPIES ACCEPTED)

MUST BE WITNESSED BY TWO PERSONS OTHER THAN BENEFICIARY (IES)

SIGNATURE OF WITNESS(Do not print or type)	SIGNATURE OF WITNESS (Do not print or type)
ADDRESS/P.O. BOX	ADDRESS/P.O. BOX
CITY STATE ZIP	CITY STATE ZIP

**BOARD OF TRUSTEES
EMPLOYEES' RETIREMENT SYSTEM
1300 PERDIDO STREET, ROOM 1E12
NEW ORLEANS, LA 70112
(504) 658-1850**

**STATUS OF RE-EMPLOYMENT WITH
CITY OF NEW ORLEANS OR MEMBER AGENCY
AFTER RETIREMENT**

I understand that **I AM NOT** allowed to work more than **17.15** hours of a thirty-five (35) hour workweek or more than **19.45** hours of a forty (40) hour workweek. I also understand that **if I work more than** the aforesaid hours, in any workweek, I must become a contributing member of the Retirement System; and **I WILL NOT** receive a retirement benefit allowance for that period.

I further understand that I **MUST** notify the Employees' Retirement System of the City of New Orleans, **if I am reemployed** by the City of New Orleans and work in excess of the hours allowed to received a benefit allowance. A **FAILURE** to properly notify the Retirement System will result in a recoupment of amounts received by the retiree.

Social Security Number

Print Name

Signature

Date

**CITY OF NEW ORLEANS CHOICE PLUS PLAN ENROLLMENT FORM
(ACTIVE EMPLOYEES AND PRE-65 RETIREES)**

PLEASE PRINT OR TYPE

LAST NAME	FIRST	INITIAL	GENDER	BIRTHDATE MM/DD/YYYY	PAY GRADE:	DEPARTMENT
ADDRESS	SOCIAL SECURITY NO:		MARRIED: Y/N DATE MARRIED:		ORGANIZATION: POLICE <input type="checkbox"/> FIRE <input type="checkbox"/> CITY <input type="checkbox"/>	
CITY	STATE	ZIP CODE	PHONE NO:	ALTERNATE NO:	ACTIVE <input type="checkbox"/> RETIREE <input type="checkbox"/> WIDOW <input type="checkbox"/>	HIRE/RETIREMENT DATE:

DO YOU WANT TO PARTICIPATE IN THE CITY'S CHOICE PLUS PLAN? YES NO IF NO, SIGN AND DATE BELOW.
 DO YOU WANT TO PRETAX YOUR HEALTHCARE PREMIUMS? YES NO
 DO YOU OR YOUR DEPENDENT(S) HAVE MEDICAID OR MEDICARE YES NO PLEASE PROVIDE EFFECTIVE DATE: _____
 DO YOU WANT TO COVER YOUR DEPENDENTS? YES NO
 IF YES, PLEASE LIST THEM BELOW. (Dependents i.e.: Spouse, Domestic Partner, Son, Daughter or Legal Custody of a child, etc.) _____

LAST NAME	FIRST	MI	GENDER	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NO.

NAME AND ADDRESS OF SPOUSE/PARTNER'S GROUP HEALTH BENEFIT CARRIER (OTHER THAN THIS PLAN)

I AUTHORIZE THE PROPER DEDUCTIONS FROM MY EARNINGS AS MY CONTRIBUTION TOWARDS THE COST OF THE CITY'S CHOICE PLUS PLAN.

EMPLOYEE'S SIGNATURE _____ DATE: _____
 HUMAN RESOURCE APPROVAL _____ DATE _____

Office use only	Codes
Effective Date	
Termination Date	
Premium Rate	
Other:	

AHRS <input type="checkbox"/>	UHC <input type="checkbox"/>	ACCESS <input type="checkbox"/>
Date Received		
Date Processed		
Processor		

**2015 CHOICE PLAN
DEDUCTION CODES & RATES
EFFECTIVE JANUARY 1, 2015**

TYPES OF COVERAGE	Ded. Code	Rate
RETIREEES UNDER 64		
Retiree Only (Compliant)	O1	\$ 293.68
Retiree Only (Non-Compliant)	U1	\$ 308.68
Retiree & Child(ren) - (Compliant)	O4	\$ 534.70
Retiree & Child(ren) - (Non-Compliant)	U4	\$ 549.70
Retiree & Spouse - RR/SP (Compliant)	O3	\$ 578.50
Retiree & Spouse - (One-Compliant)	U3	\$ 593.50
Retiree & Spouse - RRSP (Non-Compliant)	N3	\$ 608.50
Retiree & Family - RR/SP (Compliant)	O5	\$ 735.41
Retiree & Family - RR/SP (One-Compliant)	U5	\$ 750.41
Retiree & Family - RR/SP (Non-Compliant)	N5	\$ 765.41
BENEFICIARIES UNDER AGE 65		
Widow/Widower < 65 - (Compliant)	W1	\$ 288.46
Widow/Widower < 65 - (Non-Compliant)	W2	\$ 303.46
Widow/Widower < 65 & Minors - (Compliant)	W3	\$ 317.42
Widow/Widower < 65 & Minors - (Non-Compliant)	W4	\$ 332.42
DISABLED RETIREEES UNDER 65 WITH MEDICARE A & B		
Retiree Only < 65 (Compliant)	M1	\$ 201.30
Retiree Only < 65 (Non-Compliant)	M2	\$ 216.30
Retiree & Child(ren) - (Compliant)	D1	\$ 436.42
Retiree & Child(ren) - (Non-Compliant)	D2	\$ 451.42
Retiree & Spouse - RR/SP (Compliant)	D3	\$ 365.01
Retiree & Spouse - (One-Compliant)	D4	\$ 380.01
Retiree & Spouse - RR/SP (Non-Compliant)	D5	\$ 395.01
Retiree & Family - RR/SP (Compliant)	D6	\$ 411.58
Retiree & Family - RR/SP (One-Compliant)	D7	\$ 426.58
Retiree & Family - RR/SP (Non-Compliant)	D8	\$ 441.58
Widow/Widower < 65 - (Compliant)	S1	\$ 288.46
Widow/Widower < 65 - (Non-Compliant)	S2	\$ 303.46
Widow/Widower & Minors < 65 - (Non-Compliant)	S3	\$ 317.42
Widow/Widower & Minors < 65 - (Compliant)	S4	\$ 332.42
DEPENDENTS OF RETIREEES 65+		
Spouse/Partner - (Compliant)	M3	\$ 140.00
Spouse/Partner - (Non-Compliant)	M4	\$ 155.00
Spouse/Partner & Child(ren) - (Compliant)	M8	\$ 233.60
Spouse/Partner & Child(ren) - (Non-Compliant)	M6	\$ 248.60
Minor Child(ren) Only	M5	\$ 138.99
Disabled Dependent	M7	\$ 138.99
Children of Officers Killed in Line of Duty	C1	\$ 162.79

DIRECT DEPOSIT SIGN-UP FORM

(Please check one or both) Lifetime Benefit _____

Annuity _____

ATTACH VOIDED CHECK HERE
(IF CHECKING ACCOUNT)

MEMBER NO. _____

PAYEE MUST KEEP THE EMPLOYEES' RETIREMENT SYSTEM INFORMED OF ANY ADDRESS CHANGES IN ORDER TO RECEIVE IMPORTANT INFORMATION ABOUT BENEFITS AND TO REMAIN QUALIFIED FOR PAYMENT. THE AGREEMENT REPRESENTED BY THIS AUTHORIZATION REMAINS IN EFFECT UNTIL CANCELED BY THE PAYEE BY WRITTEN NOTICE TO THE RETIREMENT OFFICE, OR BY DEATH OR LEGAL INCAPACITY OF THE PAYEE. UPON CANCELLATION, THE PAYEE SHOULD NOTIFY THE RECEIVING FINANCIAL INSTITUTION THAT HE/SHE IS DOING SO.

(TO BE COMPLETED BY PAYEE)

SECTION 1

A. NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER OF PAYEE
B. MAILING ADDRESS IS THIS A NEW ADDRESS? YES ___ NO ___	TELEPHONE NUMBER OF PAYEE
C. CITY STATE ZIP CODE	TYPE OF ACCOUNT: CHECKING ___ SAVINGS ___ ACCOUNT NO. _____
<p style="text-align: center;">PAYEE CERTIFICATION</p> <p>I CERTIFY THAT I AM ENTITLED TO THE PAYMENT IDENTIFIED ABOVE. IN SIGNING THIS FORM, I AUTHORIZE MY RETIREMENT CHECK TO BE SENT TO THE FINANCIAL INSTITUTION NAMED BELOW TO BE DEPOSITED TO THE DESIGNATED ACCOUNT.</p>	<p>IF JOINT ACCOUNT: NAME OF OTHER JOINT ACCOUNT HOLDER; PHONE NO.</p>
SIGNATURE OF PAYEE DATE	ADDRESS OF OTHER JOINT ACCOUNT HOLDER
X	

(TO BE COMPLETED BY FINANCIAL INSTITUTION)

SECTION 2

NAME AND ADDRESS OF FINANCIAL INSTITUTION	TYPE OF ACCOUNT: CHECKING ___ SAVINGS ___ ROUTING NO. _____ ACCOUNT NO. _____ NAMES ON ACCOUNT _____ (MUST BE PAYEE; JOINT ACCOUNT ACCEPTABLE)		
<p style="text-align: center;">FINANCIAL INSTITUTION CERTIFICATION</p> <p>I CONFIRM THE IDENTITY OF THE ABOVE-NAMED PAYEE AND THE ACCOUNT NO. AND OWNER. AS REPRESENTATIVE OF THE ABOVE NAMED FINANCIAL INSTITUTION, I CERTIFY THAT THE FINANCIAL INSTITUTION AGREES TO RECEIVE AND DEPOSIT THE PAYMENT DESCRIBED ABOVE.</p>			
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE #	DATE

PLEASE BRING OR MAIL THIS DOCUMENT TO:

CITY OF NEW ORLEANS
EMPLOYEES' RETIREMENT SYSTEM
1300 PERDIDO STREET, STE. 1E12
NEW ORLEANS, LA 70112

DIRECT DEPOSIT SIGN-UP FORM

(Please check one or both) Lifetime Benefit _____

Annuity _____

MEMBER NO. _____

ATTACH VOIDED CHECK HERE
(IF CHECKING ACCOUNT)

PAYEE MUST KEEP THE EMPLOYEES' RETIREMENT SYSTEM INFORMED OF ANY ADDRESS CHANGES IN ORDER TO RECEIVE IMPORTANT INFORMATION ABOUT BENEFITS AND TO REMAIN QUALIFIED FOR PAYMENT. THE AGREEMENT REPRESENTED BY THIS AUTHORIZATION REMAINS IN EFFECT UNTIL CANCELED BY THE PAYEE BY WRITTEN NOTICE TO THE RETIREMENT OFFICE, OR BY DEATH OR LEGAL INCAPACITY OF THE PAYEE. UPON CANCELLATION, THE PAYEE SHOULD NOTIFY THE RECEIVING FINANCIAL INSTITUTION THAT HE/SHE IS DOING SO.

(TO BE COMPLETED BY PAYEE)

SECTION 1

A. NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER OF PAYEE
B. MAILING ADDRESS IS THIS A NEW ADDRESS? YES ___ NO ___	TELEPHONE NUMBER OF PAYEE
C. CITY STATE ZIP CODE	TYPE OF ACCOUNT: CHECKING ___ SAVINGS ___ ACCOUNT NO. _____
<p style="text-align: center;">PAYEE CERTIFICATION</p> <p>I CERTIFY THAT I AM ENTITLED TO THE PAYMENT IDENTIFIED ABOVE. IN SIGNING THIS FORM, I AUTHORIZE MY RETIREMENT CHECK TO BE SENT TO THE FINANCIAL INSTITUTION NAMED BELOW TO BE DEPOSITED TO THE DESIGNATED ACCOUNT.</p>	<p>IF JOINT ACCOUNT: NAME OF OTHER JOINT ACCOUNT HOLDER; PHONE NO.</p>
SIGNATURE OF PAYEE DATE	ADDRESS OF OTHER JOINT ACCOUNT HOLDER

X

(TO BE COMPLETED BY FINANCIAL INSTITUTION)

SECTION 2

NAME AND ADDRESS OF FINANCIAL INSTITUTION	TYPE OF ACCOUNT: CHECKING ___ SAVINGS ___ ROUTING NO. _____ ACCOUNT NO. _____ NAMES ON ACCOUNT _____ _____ (MUST BE PAYEE; JOINT ACCOUNT ACCEPTABLE)
---	---

FINANCIAL INSTITUTION CERTIFICATION

I CONFIRM THE IDENTITY OF THE ABOVE-NAMED PAYEE AND THE ACCOUNT NO. AND OWNER. AS REPRESENTATIVE OF THE ABOVE NAMED FINANCIAL INSTITUTION, I CERTIFY THAT THE FINANCIAL INSTITUTION AGREES TO RECEIVE AND DEPOSIT THE PAYMENT DESCRIBED ABOVE.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE #	DATE
-------------------------------------	-----------------------------	-------------	------

LEASE BRING OR MAIL THIS DOCUMENT TO:

CITY OF NEW ORLEANS
 EMPLOYEES' RETIREMENT SYSTEM
 1300 PERDIDO STREET, STE. 1E12
 NEW ORLEANS, LA 70112

**Withholding Certificate for
 Pension or Annuity Payments**

2015

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 payments to U.S. citizens 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 do not file a Form W-4P for 2015.

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 do not 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. The IRS has created a page on www.irs.gov/w4p. Information about any future developments affecting Form W-4P (such as legislation enacted after we release it) will be posted on that page.

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 are single and have only one pension; or
- You are 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 are 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 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 \$65,000 (\$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 \$65,000 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 are **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.

**Withholding Certificate for
 Pension or Annuity Payments**

2015

▶ 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.) ▶ _____

Marital status: Single Married Married, but withhold at higher Single rate. (Enter number of allowances.)

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 ▶

CHECK LIST FOR EXITING DROP

1. CERTIFICATION AT END OF PARTICIPATION/EMPLOYMENT (RS-11.3) _____
2. DROP WITHDRAWAL METHOD SELECTION (RS11.4) _____
3. DROP INSTALLMENT PAYMENT ELECTION FORM _____
4. DIRECT DEPOSIT SIGN-UP FORM _____
5. STATUS OF RE-EMPLOYMENT WITH CITY OF NEW ORLEANS _____
6. HOSPITALIZATION FORM _____
7. W4P- WITHHOLDING CERTIFICATE _____

**PLEASE RETURN THE ABOVE
COMPLETED DOCUMENTS TO THE
ATTENTION OF:**

**CITY OF NEW ORLEANS
EMPLOYEES' RETIREMENT SYSTEM
1300 PERDIDO STREET
CITY HALL, ROOM 1E12
NEW ORLEANS, LA 70112**