AUTHORIZATION FOR DIRECT DEPOSIT OF MONTHLY BENEFIT

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, Virginia 23218-2500
Toll-free 1-888-VARETIR (827-3847)
Fax 1-804-786-9718
www.varetire.org

Clear Form

1. Social Security Number	
2. Phone Number	

If you are a Power of Attorney or guardian for a retiree or survivor, please attach a copy of your Power of Attorney or guardianship papers. If you are filling this out on behalf of a retiree or beneficiary in the State Retiree Health Benefits Program and the address is being updated, the address change will not be made unless the Power of Attorney specifically authorizes access to health plan information.

VRS will send you a Statement of Benefits when the first benefit payment is made into the new account. If your mailing address changes, it is very important to notify VRS so you'll receive important information that is mailed to your mailing address, including the year-end tax statement and newsletters.

Note: If you receive more than one benefit from VRS, this authorization applies to all benefits you receive.

3. Name (First, Middle Initial, Last)

4. Address (Street, City, State and ZIP+4) ❑ Check here if a new address

5. Type of Request (Choose one)

❑ New Retiree (Initial Request) ❑ New Survivor (Initial Request)
❑ Third Party (Initial Request) ❑ Change of Direct Deposit Information

6. Financial Institution Name

7. Financial Institution Account Information

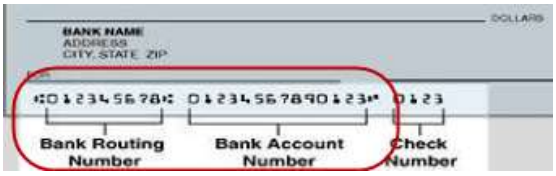
Account Type (Choose one): ❑ Checking ❑ Savings

Bank Routing Number

Account Number

Note: If you have fraud control or protection measures on this account, you may want to check with your financial institution before VRS sends your first payment to be sure it is not rejected.

Tip: Locate the bank routing and account numbers at the bottom of your deposit slip or check.



8. Authorization and Signature (Required for Processing)

I hereby authorize VRS to deposit my monthly retirement benefit payment directly to my account at the financial institution shown above. I agree to provide written notification to VRS within 30 days of any changes to this information so that my monthly benefit may be properly distributed. I also authorize VRS to make adjustments to my account to correct any credit entries made in error.

Signature _____ Date _____