

REQUEST FOR ESTIMATE OF DISABILITY RETIREMENT BENEFITS

VIRGINIA RETIREMENT SYSTEM
 P.O. Box 2500
 Richmond, Virginia 23218-2500
 Toll Free 1-888-VARETIR (827-3847)
 www.varetire.org

1. Employer Code
2. Social Security Number

Complete this form in its entirety to ensure that VRS has all information necessary to provide you an estimate.

MEMBER INFORMATION (Please print)

3. Name (First) (MI) (Last) (Jr./Sr.)			
4. Address (Street) (City) (State) (Zip+4)			
5. Home Phone Number ()	6. Daytime Phone Number ()	7. Date of Birth (mm/dd/yy)	
8. Anticipated Retirement Date (mm/01/yy) _____ / 01 / _____		9. Employment Termination Date (mm/dd/yy)	
10. This estimate is for: (Check One) <input type="checkbox"/> Disability not compensable under Virginia Workers' Compensation Act <input type="checkbox"/> Disability compensable under Virginia Workers' Compensation Act			
11. Have you applied for Social Security disability benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, provide a copy of the receipt from Social Security.)			
12. Amount of your Workers' Compensation Award (If known)			
13. Retirement Payout Options (Check the retirement options for which you would like an estimate.) <input type="checkbox"/> Basic Benefit <input type="checkbox"/> Survivor Option, with _____ payable to my survivor			

If you chose the Survivor Option in Box 13, complete Boxes 14-16.

14. Survivor's/Contingent Annuitant's Name (First) (MI) (Last) (Jr./Sr.)			
15. Survivor's/Contingent Annuitant's Date of Birth (mm/dd/yy)	16. Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other		
17. Member Authorization _____ Signature _____ Date			

