

REQUEST FOR TERMINATION OF MONTHLY BENEFIT

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

1. Social Security Number
2. Daytime Phone Number

Complete this form to terminate your monthly benefit if you return to employment covered under the Virginia Retirement System (VRS). Your monthly benefit must be terminated effective with the same month that you begin employment. You will be responsible for returning any benefit payments that are paid to you beyond that date. Your group life insurance coverage will be based on your new salary (even if it is lower) unless your first retirement was on or after July 1, 1999 and you had 20 years or more of service. In this case, your life insurance amount will be based on your highest annual salary during your career.

PART A. RETIREE INFORMATION

3. Name	(First)	(MI)	(Last)	(Jr./Sr.)
4. Address	(Street)		(City)	(State) (Zip+4)
5. Employer at Time of Retirement	6. Retirement Date			
7. Retiree Acknowledgement				
I am returning to work with the VRS-covered employer as shown below.				
_____ Signature			_____ Date	

PART B. CURRENT EMPLOYER CERTIFICATION

8. Employer Name	9. Employer Code
10. Address	(Street) (City) (State) (Zip+4)
11. Effective Date of Employment	12. Payroll Date Member to be Reported to VRS
13. Employer Authorization	
The individual named above has been employed as a permanent, full-time classified employee and will be reported to VRS as an active member.	
Personnel Authorization	Payroll Authorization
_____ Signature	_____ Signature
_____ Phone Number	_____ Phone Number
_____ Date	_____ Date
14. Contact Information	
Provide a contact to whom VRS may direct questions about the information shown above. (Please print)	
_____ Name	_____ E-mail Address
_____ Phone Number	