# 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***

Clear Form

| **1. Social Security Number** |
|---|
| **2. Employer Code** |

*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, Middle Initial, Last)

**4. Address** (Street, City, State and Zip+4)

| **5. Home Phone Number** | **6. Daytime Phone Number** | **7. Date of Birth** (mm/dd/yy) |
|---|---|---|
| | | |

| **8. Anticipated Retirement Date** (mm/01/yy) | **9. Employment Termination Date** (mm/dd/yy) |
|---|---|
| _____ / 01 / _____ | |

**10. This estimate is for:** (Check One)

❑ Disability **not** compensable under Virginia Workers' Compensation Act

❑ Disability compensable under Virginia Workers' Compensation Act

**11. Have you applied for Social Security disability benefits?**

❑ No ❑ 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.)**

❑ Basic Benefit ❑ 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, Middle Initial, Last)

| **15. Survivor's/Contingent Annuitant's Date of Birth** (mm/dd/yy) | **16. Relationship** ❑ Spouse ❑ Other |
|---|---|
| | |

**17. Member Authorization**

_____ _____

Signature Date

VRS-6C (Rev. 02/11)