

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. 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) ____ / 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, Middle Initial, Last)		
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

