

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

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 Earnings 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)	<input type="checkbox"/> Check here if a new address
5. Type of Request (Choose one) <input type="checkbox"/> New Retiree (Initial Request) <input type="checkbox"/> New Survivor (Initial Request) <input type="checkbox"/> Third Party (Initial Request) <input type="checkbox"/> Change of Direct Deposit Information	
6. Name of Financial Institution	7. Branch (City and State)
8. Type of Account (Choose one) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
9. 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 below. 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 _____	
10. Provide a voided check with the correct routing information and account number. To ensure the information you provide is accurate, you may wish to contact your financial institution. TAPE VOIDED CHECK WITHIN THE LINES OF THIS BOX	

