



RICHMOND RETIREMENT SYSTEM BENEFIT INFORMATION REQUEST FORM

PART A. MEMBER INFORMATION

Name:		
SSN:	Phone Number:	
Address:		
City:	State:	Zip Code:

PART B. TYPE OF REQUEST - Request will be processed within 5 business days of receipt

<input type="checkbox"/> Contribution Account Balance	<input type="checkbox"/> Copy of Beneficiary Form
<input type="checkbox"/> Proof of Prior Health Coverage	<input type="checkbox"/> Value of Life Insurance Policy
<input type="checkbox"/> Copy of Tax Withholding Certificate Federal State Both	<input type="checkbox"/> Copy of Check Stub For what period? _____
<input type="checkbox"/> Duplicate 1099-R Request Year(s) Requested: _____	<input type="checkbox"/> Pension Verification Year(s) Requested: _____

PART C. DELIVERY METHOD (Choose One)

<input type="checkbox"/> In Office Pick Up (<i>ID will be required</i>)	<input type="checkbox"/> United States Mail
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PART D. CERTIFICATION

I certify that the information provided on this form is true and accurate to the best of my knowledge.	
_____ Member's Signature	_____ Date

Return Form to: Richmond Retirement System 900 E. Broad Street, Room 400 Richmond, Virginia 23219 (804) 646-5958 (804) 646-5299 Fax
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