RICHMOND RETIREMENT SYSTEM
City of Richmond, Virginia

RETIREMENT APPLICATION

PART A. MEMBER INFORMATION

1. Name:	2. SSN:	3. Birth Date:
John B. Doe	111-22-3333	07/01/52

4. Address:	5. Phone Number:
900 East Broad Street, Richmond, Virginia 23219	(804) 646-5958

6. Department:	7. Retirement Date:
Retirement	07/01/12

8. Membership Plan (Choose One)

✓ Defined Benefit ____ Defined Benefit with Enhanced Option ____ Defined Contribution

PART B. TYPE OF RETIREMENT (refer to eligibility requirements)

9. Type of Retirement (Choose One)

____ Service (Normal Retirement) ✓ Early Service (Age & Service) ____ Early Service (Service)

____ Deferred Service ____ Deferred Early Service ____ Deferred Early Service (DC Plan)

PART C. PAYMENT BENEFIT OPTION (refer to benefit payment options)

10. Benefit Payment Options (Choose One)

____ Basic Benefit ____ Level Payment ____ Smooth-Out

_____% Pop-Up Joint and Last Survivorship 100 % Joint and Last Survivorship

PART D. SURVIVOR INFORMATION Please complete Part D only if you chose a survivor option in Part C.

11. Name:	12. SSN:	13. Birth Date:
Mary B. Doe	222-33-4444	09/15/54

14. Address:	15. Relationship:
900 East Broad Street, Richmond, Virginia 23219	✓ Spouse ____ Other

PART E. CERTIFICATION

16. Member's Certification

I hereby certify that: 1) all of the foregoing facts are correct, 2) I have read and understand the service retirement information in the Members Handbook, 3) I have satisfied the retirement eligibility requirements set forth in the City of Richmond Code Chapter 78 and 4) I fully understand Article IX of Chapter 78 of the City of Richmond Code governing payment options available to me. I further understand that I must 1) submit proof of my birth date, 2) submit proof of my contingent beneficiary's birth date, if I elect a survivorship option, 3) enroll in health/dental insurance program, if eligible; within 30 days from the date of my retirement or be subject to the re-enrollment provision of the City's and 4) enroll in the direct deposit program to receive my benefits. Additionally, I agree that I or my estate will repay any excess payment of benefits to which I was not entitled.

_____

Member's Signature **Date**

TO BE COMPLETED BY NOTARY or by other Court Official authorized to take acknowledgements:

State of _____ City/County of _____ on _____ 20 ___

The individual whose name is signed above appeared before me, acknowledged the signature to be his/her, and having been duly sworn by me, made an oath that the statements are true.

_____ My commission expires: _____

Notary Public Notary Registration Number: _____

RRS Use Only

Board of Trustees Agenda _____ _____ _____

1st Reviewer Date

Member's Age _____

Member's Creditable Service_____ _____ _____

2nd Reviewer Date

revised 3/08

RICHMOND RETIREMENT SYSTEM (RRS)
BENEFICIARY APPOINTMENT/CHANGE FORM

(Please read the information on the reverse page prior to the completion of this form.)

Check One: ✓ Original Appointment ____ Change Employment Status: . Active ✓ . Retired

Name: John B. Doe Active Register No.: 5000

Address: 900 East Broad Street Retirement No.: _____

Richmond, Virginia 23219 Social Security No.: 111-22-3333

BENEFICIARY DESIGNATION FOR RRS MEMBERS

I, John B. Doe, do hereby designate in accordance with Section 78 of the City Code governing the operation of the Richmond Retirement System, the below named person(s) to receive the following proceeds, if applicable: one time lump-sum death benefit payment; refund of my retirement contributions and/or funds accumulated in my Deferred Retirement Option Program (DROP) account upon my death.

1. Primary Beneficiary Name and Address	**Relationship**	**Date of Birth**	**Social Security Number**
Mary B.Doe 900 East Broad Street Richmond, VA 23227	Wife	09/15/1954	222-33-4444
2. Primary Beneficiary Name and Address	**Relationship**	**Date of Birth**	**Social Security Number**
3. Contingent Beneficiary Name and Address	**Relationship**	**Date of Birth**	**Social Security Number**

I hereby direct that should I survive the above-named beneficiary(ies), any such benefit(s) aforementioned shall be paid to my estate or to such other beneficiary(ies) as I shall hereafter nominate by written designation, duly acknowledged and filed prior to my death with the System in accordance with the laws governing the operation of the System.

Member's Signature: _____ Date: _____

THE FOLLOWING CERTIFICATION MUST BE EXECUTED BY A NOTARY PUBLIC OR OTHER COURT OFFICIAL AUTHORIZED TO TAKE ACKNOWLEDGEMENTS. THIS FORM IS NOT VALID UNLESS PROPERLY NOTARIZED.

State of _____ City/County of _____ on _____ 20 _____

The individual whose name is signed above appeared before me, acknowledged the foregoing signature to be his/hers, and having been duly sworned by me made an oath that the statements in the said instrument are true.

_____ Notary registration number: _____

Notary Public

My commission expires: _____

Rev. 03/2008

RICHMOND RETIREMENT SYSTEM

Health/Dental Insurance Deduction Authorization Form

PART A. MEMBER INFORMATION

1. Name:	2. SSN:	3. Birth Date:
John B. Doe	111-22-3333	07/01/52

4. Address:	5. Phone Number:
900 East Broad Street, Richmond, Virginia 23219	(804) 646-5958

6. Eligible for City Post-Retirement Benefits	7. Employment Date:	8. Retirement Date:
✓ Yes ___ No	06/16/82	07/01/12

PART B. HEALTH INSURANCE COVERAGE

9. Type of Plan (Choose One)

✓ Southern Health HMO ___ Southern Health POS ___ Southern Health PPO

___ Decline Health Insurance (Waiver)

10. Type of Coverage (Choose One)

___ Retiree Only ✓ Retiree + One ___ Family ___ Dependent Only (Non Medicare Eligible)

PART C. DENTAL INSURANCE COVERAGE

11. Type of Plan (Choose One)

✓ DeltaCare ___ Delta Dental PPO ___ Decline Dental (Waiver)

12. Type of Coverage (Choose One)

___ Retiree Only ✓ Retiree + One ___ Family

13. Dental Office Selection (Only for DeltaCare Program)

Dr. Dental Care

PART D. DEPENDENT INFORMATION. Complete Part D only if you chose Retiree + One or Family Coverage.

14. Name:	15. SSN	16. Sex	17. Birth Date	18. Dental Office Selection or PCP
Mary B. Doe	222-33-4444	F	09/15/54	Dr. Best Dentist

PART E. MEMBER CERTIFICATION

I hereby certify that: 1) all of the foregoing facts are correct, 2) I have participated in the City's Health insurance program continuously for the last five (5) years, 3) I understand that I have thirty (30) days, before termination of benefits, to enroll in health and/or dental insurance after my retirement date. The Richmond Retirement System is hereby authorized to deduct such amount as may be necessary for the payment of my premiums for the above elected health and/or dental coverage from my pension benefit. This authorization will remain in effect until revoked by me, loss of eligibility to participant in the City's benefits program or until my death.

Member's Signature **Date**

RRS Use Only

Processed with Vendor(s)_____ Set Up on Payroll System _____ Journal Reviewed _____ Sent to HR: _____

Health Transfer Date:_____ Health Deduction Amount: _____

Dental Transfer Date:_____ Dental Deduction Amount:_____

Rev. 12/2008

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

OMB No. 1545-0074

2009

Purpose. Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W-4P to choose (a) not to have any federal income tax withheld from the payment (except for eligible rollover distributions, or payments to U.S. citizens delivered outside the United States or its possessions) or (b) to have an additional amount of tax withheld.

Your options depend on whether the payment is periodic, nonperiodic, or an eligible rollover distribution, as explained on pages 3 and 4. Your previously filed Form W-4P will remain in effect if you do not file a Form W-4P for 2009.

What do I need to do? Complete lines **A** through **G** of the **Personal Allowances Worksheet**. Use the additional worksheets on page 2 to further adjust your withholding allowances for itemized deductions, adjustments to income, certain credits, or multiple pensions/more-than-one-income situations. If you do not want any federal income tax withheld (see *Purpose* above), you can skip the worksheets and go directly to the Form W-4P below.

Sign this form. Form W-4P is not valid unless you sign it.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one pension; or
- You are married, have only one pension, and your spouse has no income subject to withholding; or
- Your income from a second pension or a job, or your spouse's pension or wages (or the total of all) is $1,500 or less.

. . . . . **B** _____

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a spouse who has income subject to withholding or you have more than one source of income subject to withholding. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return . . . . . **E** _____

F **Child Tax Credit** (including additional child tax credit):
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children . . . . . **F** _____

G Add lines A through F and enter total here. (**Note.** *This may be different from the number of exemptions you claim on your tax return.*) . . . . . ▶ **G** 0

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have more than one source of income subject to withholding or a spouse with income subject to withholding **and** your combined income from all sources exceeds $40,000 ($25,000 if married), see the **Multiple Pensions/More-Than-One-Income Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line G on line 2 of Form W-4P below.

---------- **Cut here and give Form W-4P to the payer of your pension or annuity. Keep the top part for your records.** ----------

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments

▶ **For Privacy Act and Paperwork Reduction Act Notice, see page 4.**

OMB No. 1545-0074

2009

Type or print your first name and middle initial.	Last name	**Your social security number**
John B.	Doe	111 ¦ 22 ¦ 3333

Home address (number and street or rural route)
900 East Broad Street

City or town, state, and ZIP code
Richmond, Virginia 23219

Claim or identification number (if any) of your pension or annuity contract

Complete the following applicable lines.

1 Check here if you **do not want any** federal income tax withheld from your pension or annuity. (Do not complete lines 2 or 3.) ▶ ☐

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or annuity payment. (You may also designate an additional dollar amount on line 3.) . . . . . ▶ 0 (Enter number of allowances.)

Marital status: ☐ Single ☑ Married ☐ Married, but withhold at higher "Single" rate

3 Additional amount, if any, you want withheld from each pension or annuity payment. (**Note.** *For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.*) . . ▶ $

Your signature ▶ **Date ▶**

Retiree No.: _____

FORM VA-4P INSTRUCTIONS
VIRGINIA DEPARTMENT OF TAXATION
WITHHOLDING EXEMPTION CERTIFICATE FOR RECIPIENTS OF PENSION AND ANNUITY PAYMENTS

Use this form to notify your pension administrator or other payer whether income tax is to be withheld, and on what basis.

Am I required to file Form VA-4P? Yes. You MUST file Form VA-4P with your pension or annuity payer before your payments begin. If you do not file Form VA-4P, your payer is required to withhold Virginia income tax from your payments as if you had claimed zero exemptions.

Can I elect "no withholding"?. You may use this form to elect "no withholding" if you have made a similar election for federal purposes, or if you meet any of the conditions listed in the instructions for Line 4 of Form VA-4P on the reverse side of this sheet.

What if I have other income? If you have income from other sources which is not subject to Virginia income tax withholding, you should consider making estimated tax payments on form 760-ES, or requesting that an additional amount of tax be withheld from your pension or annuity payment. You can download Form 760-ES or electronically file your estimated payment on our website, **www.tax.virginia.gov**. You may also order Form 760-ES by calling (804) 440-2541 or contacting your local commissioner of the revenue.

How do I complete Form VA-4P? Be sure to read the instructions on the reverse side of this page carefully before completing Form VA-4P. If you need assistance, you may contact the Department of Taxation at (804) 367-8037.

PERSONAL EXEMPTION WORKSHEET

1.	Enter "1" for yourself		
2.	If you are married and your spouse is not claimed on his or her own certificate, enter "1"		
3.	Enter the number of dependents you will claim on your income tax return (do not include your spouse)		
4.	Subtotal of Personal Exemptions - add lines 1 - 3		0
5.	Exemptions for age		
	a) It you will be 65 or older on January 1, enter "1"		
	b) If you claimed an exemption on line 2 above and your spouse will be 65 or older on January 1, enter "1"		
6.	Exemptions for blindness		
	a) If you are legally blind enter "1"		
	b) It you claimed an exemption on line 2 above and your spouse is legally blind, enter "1 "		
7.	Subtotal of Age and Blindness Exemptions - add lines 5 & 6		0
8.	**Total exemptions (add lines 4 and 7)**		0

CUT HERE AND SEND TO THE PAYER OF YOUR PENSION OR ANNUITY

FORM VA-4P Virginia Withholding Exemption Certificate for Recipients of Pension and Annuity Payments

Your Social Security Number	Name	
111-22-3333	John B. Doe	
Street Address		
900 East Main Street		
City	State	Zip Code
Richmond	Virginia	23219

Complete the applicable lines below:

1.	If subject to withholding, enter the number of exemptions claimed on	
	(a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet	0
	(b) Subtotal of Age and Blindness Exemptions - line 7 of the Personal Exemption Worksheet	0
	(c) Total Exemptions - line 8 of the Personal Exemption Worksheet	0
2.	Enter the amount of additional withholding requested (see instructions)	
3.	Enter the amount of voluntary withholding requested (see instructions)	
4.	I certify that I am not subject to Virginia withholding, either because I have elected "no withholding" for federal purposes, or I meet the conditions for exemption set forth in the instructions for Form VA-4P. (Check here.)	☐

Signature _____ Date _____

2601062 Rev. 11/07

CITY OF RICHMOND
RICHMOND RETIREMENT SYSTEM

DIRECT DEPOSIT AUTHORIZATION

(Please type or print in ink)

Name: John B. Doe Social Security No.: 111-22-3333

Address: 900 East Broad Street

City: Richmond State: Virginia Zip Code: 23219

Phone: (804) 646-5958

I hereby authorize the Richmond Retirement System (RRS) to deposit my monthly retirement benefit payment directly to my account at the financial institution shown below. I agree to provide written notification to RRS within 30 days of any changes to this information so that my monthly benefit may be properly distributed. I also authorize RRS to make adjustments to my account to correct any credit entries made in error.

I understand that I must check with my financial institution to verify that my account has in fact been credited before engaging in any financial transaction, which is dependent on the existence of the credit entry.

This authority is to remain in effect until the RRS receives written notification from me of its termination in such time and in such manner as to afford the RRS a reasonable opportunity to act on it.

Member's Signature: _____ Date: _____

NOTE: Direct deposit will be effective two months after processing for payroll.

FIRST MONTH: Pension check will be mailed to your home.

SECOND MONTH: Funds will be direct deposited into your bank account.

Name of Depository/Bank: Bank of Retirement

Type of Account (***Please check one***):

- ☑ Checking - Attach a voided **check** or bank authorization form
- ☐ Savings - Attach a **deposit slip** or bank authorization form

Rev. 8/07