

NAME AND ADDRESS DECLARATION



VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ♦ Richmond, VA 23218-2500
Toll-free 1-888-827-3847
Fax 804-786-9718
www.varetire.org

1. Social Security Number

2. Phone Number

Retirees and survivors complete this form to update their name and/or mailing address. Please allow 30 days for changes to become effective. If you are changing your name, please provide legal proof of your new name. Include a legible copy of your marriage certificate, divorce decree or other legal court order showing your new name when submitting this form to the Virginia Retirement System (VRS).

If you are completing this form as Power of Attorney or guardian for a retiree or beneficiary, attach a copy of your Power of Attorney or guardianship papers.

State Retiree Health Benefits Program Participants:

If you are updating your address, your health plan record also will be updated and all health plan correspondence, including Explanations of Benefits, will be mailed to this address.

If you are filling this out on behalf of a retiree, survivor or beneficiary in the State Retiree Health Benefits Program, address changes will not be made unless the Power of Attorney specifically authorizes access to health plan information.

If you are only changing your address, your changes take effect immediately when you use your online account at myVRS.varetire.org. (Through myVRS, you also can update tax withholdings, print income verification statements and more.)

Please type or print clearly.

3. Name (First, Middle Initial, Last)	4. Status (Choose one) <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor
5. Are you changing your name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter your new name below and provide legal proof of your new name (e.g., court order, marriage certificate, divorce decree). Enter New Name: _____	
6. Are you changing your address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter your new address below. Enter New Address: Street Address: _____ City, State and ZIP+4: _____	
7. Authorization _____ Signature _____ Date	

