

RETIREMENT ESTIMATE FORM

NAME: _____ Org: _____

RETIREMENT PLAN: _____ CSRS _____ OFFSET _____ FERS
COVERED UNDER SPECIAL RETIREMENT (FF/LEO): ___ YES ___ NO

DATE OF RETIREMENT: _____

ESTIMATED SICK LEAVE BALANCE: _____

FOR YOUR ESTIMATE, DO YOU WANT:

HEALTH BENEFITS: ___ YES ___ NO

PLAN NUMBER: _____

LIFE INSURANCE: ___ YES ___ NO

_____ Basic If yes, reduced: _____ None _____ 50% _____ 75%

_____ Option A

_____ Option B If yes, reduced: _____ Full _____ No reduction

_____ Option C If yes, reduced: _____ Full _____ No reduction

SPOUSE ANNUITY: ___ YES ___ NO

If yes, _____ FULL _____ PARTIAL (If CSRS, give \$\$ amount)

Federal (only) Tax Withholdings:

_____ Single(including head of household) _____ Married

_____ Number of withholding allowances to be claimed

IF YOU HAD ANY OF THE FOLLOWING:

DID YOU PAY YOUR TEMPORARY TIME: ___ YES ___ NO ___ NA

DID YOU PAY YOUR MILITARY DEPOSIT: ___ YES ___ NO ___ NA

DID YOU WITHDRAW RETIREMENT CONTRIBUTIONS AND THEN MAKE A REDEPOSIT?

_____ YES _____ Date of Withdraw _____ NO _____ NA