



**CITY OF MILWAUKEE  
EMPLOYEES' RETIREMENT SYSTEM**

MARK (X) FOR EACH ESTIMATE REQUESTED

- SR    OD    DD    55/30  
 DR    ER    IS    PSO

PSO Deadline: \_\_\_\_\_

Person ID: \_\_\_\_\_

**MERITS  
MEMBER SERVICES  
RETIREMENT ESTIMATE REQUEST**

Validate: \_\_\_\_\_  
Audit: \_\_\_\_\_

<b>RETIREMENT DATE</b>			
<b>NAME</b>	FIRST	LAST	
<b>SOCIAL SECURITY NO</b>			
<b>PHONE NO</b>	HOME	WORK	
<b>DATE OF BIRTH</b>			
<b>MAIL ESTIMATE TO</b>	ADDRESS _____		
	CITY	STATE	ZIP
<b>DEPARTMENT</b>			
<b>JOB TITLE</b>			
<b>SURVIVOR NAME</b>			
<b>RELATIONSHIP</b>		<b>Social Security #</b>	
<b>DATE OF BIRTH</b>			
<b>UNION AFFILIATION</b>	MANAGEMENT <input type="checkbox"/> NON-REPRESENTED <input type="checkbox"/> REPRESENTED <input type="checkbox"/> UNION NAME _____ LOCAL _____		
<b>STATE RECIPROCITY</b>	<input type="checkbox"/>	<b>STATE SERVICE CREDIT</b>	<input type="checkbox"/>
<b>CITY/COUNTY TRANSFER</b>	<input type="checkbox"/>	<b>COUNTY/CITY TRANSFER</b>	<input type="checkbox"/>
<b>SEASONAL LABOR</b>	<input type="checkbox"/>	<b>MILITARY SERVICE CREDIT</b>	<input type="checkbox"/>

**AGE 62 SS AMOUNT**  
 Monthly amt x 12 = Annual \$ \_\_\_\_\_ (From member's most recent statement from SS)

**DISABILITY ONLY**

**Duty Related Injury:**  
**Last Day on Payroll:** \_\_\_\_\_  
**Last Day at Work:** \_\_\_\_\_  
**Date of Injury:** \_\_\_\_\_  
**Dr. Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**CSZ:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Medical Condition:**

**Comments:**

**Received on:** \_\_\_\_\_  
**Pension Specialist:** \_\_\_\_\_