Request for Verification of Benefits

AS 1830 (Rev. 8/10)

CalSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 85
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

Complete this form to request a Verification of Benefits letter. Please allow up to 30 days for CalSTRS to respond.

Section 1: Benefit Recipient Information

BENEFIT RECIPIENT NAME (LAST, FIRST, INITIAL) | CLIENT ID OR SOCIAL SECURITY NUMBER

STREET ADDRESS | (APT #)

CITY | STATE | ZIP CODE | DATE OF BIRTH (MM/DD/YYYY)

( ) TELEPHONE NUMBER | ( ) ALTERNATE NUMBER | ( ) FAX NUMBER

Section 2: Third Party Information

NAME OF REPRESENTATIVE

BUSINESS NAME

BUSINESS ADDRESS (STREET)

CITY | STATE | ZIP CODE

( ) TELEPHONE NUMBER | ( ) ALTERNATE NUMBER | ( ) FAX NUMBER

AS1830

CALSTRS
HOW WILL YOU SPEND YOUR FUTURE?

Name _____ Client ID or SSN _____

Section 3: Letter Details and Mailing

Select the type of letter you wish to receive:

☐ **Verification of Benefits duration letter**

All Verification of Benefits duration letters include the following information for all benefits:

- Benefit type
- Initial benefit effective date
- Benefit end date

☐ **Verification of Benefits duration and amounts letter**

All Verification of Benefits duration and amounts letters include the following information for all benefits:

- Benefit type
- Initial benefit effective date
- Benefit end date
- Gross monthly amount
- Quarterly supplemental amount (if applicable)

Send letter to:

☐ Third party only (copy will be mailed to benefit recipient)

By: ☐ Fax ☐ Mail

☐ Benefit recipient only

By: ☐ Fax ☐ Mail

If you have questions or need additional information, call CalSTRS at 800-228-5453, e-mail us at CalSTRS.com/contactus, fax us at 916-414-5474, or write to us at P.O. Box 15275 • MS 85 • Sacramento, CA 95851-0275.

Section 4: Signatures

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I authorize CalSTRS to release any information requested by _____
THIRD PARTY NAME

regarding any benefits paid to me or my dependents. This authorization expires 60 days after I sign this form.

_____
PRINT NAME OF BENEFIT RECIPIENT

Signature

_____ _____
BENEFIT RECIPIENT SIGNATURE DATE (MM/DD/YYYY)