CITY OF MILWAUKEE
EMPLOYES' 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: _____

RETIREMENT DATE			
NAME	FIRST	LAST	
SOCIAL SECURITY NO			
PHONE NO	HOME	WORK	
DATE OF BIRTH			
MAIL ESTIMATE TO	ADDRESS CITY	STATE	ZIP
DEPARTMENT			
JOB TITLE			
SURVIVOR NAME			
RELATIONSHIP		**Social Security #**	
DATE OF BIRTH			
UNION AFFILIATION	MANAGEMENT ☐ NON-REPRESENTED ☐ REPRESENTED ☐ UNION NAME	LOCAL	

STATE RECIPROCITY ☐
CITY/COUNTY TRANSFER ☐
SEASONAL LABOR ☐

STATE SERVICE CREDIT ☐
COUNTY/CITY TRANSFER ☐
MILITARY SERVICE CREDIT ☐

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: _____