Virginia Retirement System

Defined Contribution Plans
Request for Mistake-of-Fact Review

Date of Request: Date received by VRS:

❑ Check this box if you have or will correct this mistaken contribution by a payroll adjustment that causes current pay period contributions to be negative. Pay date on which negative occurs: _____ ; Amount: _____

Plan Information — Indicate for which Plan(s) this review is requested (check all that apply):

❑ 457 Plan ❑ Cash Match Plan ❑ Other: _____

Effective date of Payroll Authorization _____ ❑ Paper ❑ Electronic

If the employee completed a paper enrollment form, include a copy of that form and the most recent Payroll Authorization Form with this request.

Agency Information:

Agency Name | Agency Number | Contact Submitting Request

Agency Address | City | Zip Code

Fax Number | Phone Number | Email Address

Please indicate the address and contact name of the payroll office for which any employer refund will be sent, if different from that indicated above. ***CIPPS Agencies: Payment will be sent to DOA.***

Employee/Participant Information:

Last Name | First Name | Middle Name

Home Address | City | State | Zip Code

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Social Security Number | Employee Number (Mandatory for CIPPS Agencies) | Date of Birth

Employment Date with your agency _____ ❑ Wage ❑ Salaried

Mistake — Provide the details of this mistake (include additional sheets as needed):

Fax this form and any supporting documentation to **804-786-1541**, **ATTENTION: Bridgette Watkins**