



Appeal of *Strunk and City of Eugene* Calculation

Section A: Applicant information (Type or print clearly in dark ink. Illegible forms may be returned to applicant. This could delay your request.)

First name	MI	Last name	Social Security number*								
			<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
Mailing address (street or PO box)			PERS number (optional)								
City	State	Zip	Country								
Day phone number	Evening phone number		E-mail (optional)								

Section B: Calculation/adjustment appeal request

Please select the adjustment(s) you **disagree with** and briefly explain why **you disagree along with a statement of the relief you are requesting**. It is not necessary to fill out the entire form. Only provide information in the boxes that relate to your appeal. Attach additional sheets if necessary.

- Retirement account balance
 Before recalculation After recalculation

Explanation and relief requested

- Monthly benefit at retirement
 Before recalculation After recalculation

Explanation and relief requested

- Overpayment amount

Explanation and relief requested

- Current monthly benefit before recalculation

Explanation and relief requested

Section B: Calculation/adjustment appeal request (continued)

Your benefit after recalculation

Explanation and relief requested


Cost-of-living adjustment

Explanation and relief requested

Variable adjustment

Explanation and relief requested

Section C: Applicant signature

 _____ Date _____
Applicant signature (do not print)

Print applicant signature

You will be mailed a response letter within 45 days after your request is received.

Send form to:

**PERS Calculation Appeals
PO Box 23700
Tigard, OR 97281-3700**

*Providing your Social Security number (SSN) is voluntary. It will be used for confirmation purposes. If you choose not to supply your SSN, it may take PERS staff longer to process your form.

In compliance with the Americans with Disabilities Act, PERS will provide help filling out this form upon request. You may request help by calling 503-598-7377, toll free 888-320-7377, or TTY 503-603-7766.

Form #459-505w.pdf (4/22/2008) SL3 IIM Code: 2255

Office use only	
<input checked="" type="checkbox"/> PERS	<input type="checkbox"/> OPSRP <input type="checkbox"/> IAP
<input type="checkbox"/> Member	<input type="checkbox"/> Alternate payee
<input type="checkbox"/> Cross reference member SSN	
PPLAD	