



The Educational Employees' Supplementary Retirement System of *Fairfax County*
 8001 Forbes Place, Suite 300 - Springfield, Virginia 22151-2205
 703-426-3900 - 1-800-426-4208 - www.fcps.edu/ERFC

Federal and State Income Tax Withholding Form

Complete this form if you are a new retiree ~ **OR** ~ to request changes for existing tax withholdings on your ERFC annuity payments.

If you do not have a completed tax form on file, ERFC must withhold federal income tax based upon the rate for a married individual claiming three exemptions, and withhold state income tax for an individual with zero exemptions for the Commonwealth of Virginia.

Please print clearly

Last Name

First Name

Middle Initial

Social Security Number

Street Address

Apt #

City

State

Zip Code

Telephone # (area code-xxx-xxxx)

Check appropriate boxes ✓

Federal Income Tax

- A. Do not withhold any federal taxes from my ERFC annuity payments
- B. Using the marital status and number of exemption allowances noted below, calculate my federal income tax withholding (if any) in accordance with the IRS tax formula.

Marital Status: -Single - Married

Number of allowances or exemptions to be claimed:

-0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10 or more

Optional: Withhold the above calculated amount, plus an additional \$ _____ per month.

- C. Withhold a fixed monthly amount of \$ _____ per month.

Check appropriate boxes ✓

State Tax

- A. Do not withhold any state taxes from my ERFC annuity payments
- B. **Select State:**
- District of Columbia -North Carolina -South Carolina -Virginia -Maryland (MD: use Option D)
- C. Using the number of exemption allowances noted below, calculate my state income tax withholding (if any) using the appropriate state tax formula in accordance with IRS tax guidelines. (N/A for MD)

Marital Status: -Single - Married

Number of allowances or exemptions to be claimed:

-0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10 or more

Optional: Withhold the above calculated amount, plus an additional \$ _____ per month.

- D. Withhold a fixed monthly amount of \$ _____ per month. (Only \$5.00 increments for MD)

Signature

Date