

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE COMMISSIONED CORPS

REQUEST FOR VOLUNTARY STATE INCOME TAX WITHHOLDING FROM RETIRED PAY

Based on the following information, I voluntarily request that State income tax be withheld from my Public Health Service Commissioned Corps retired pay by the Compensation Branch, Division of Commissioned Personnel.

FULL NAME	(Print or type)
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CURRENT MAILING ADDRESS	(Street Address, Apt. Number)
	(City, State, ZIP)

SOCIAL SECURITY NUMBER				—			—				
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AMOUNT TO WITHHOLD MONTHLY	\$.00
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- NOTE: (1) The amount to withhold must be an even dollar amount.
(2) The amount to withhold must not be less than \$10.00 a month.
(3) The amount to withhold must not be less than the State's minimum withholding amount if that amount is higher than \$10.00 a month.

NAME STATE DESIGNATED TO RECEIVE THE ABOVE AMOUNT	
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SIGNATURE

DATE

Please return this form to:

Division of Commissioned Personnel
ATTN: Compensation Branch
5600 Fishers Lane, Room 4-50
Rockville, MD 20857-0001

PRIVACY ACT NOTICE

System of Records: 09-40-0001, "PHS Commissioned Corps General Personnel Records," HHS/PSC/HRS and 09-40-0010, "Pay, Leave and Attendance Records," HHS/PSC/HRS.

General: This statement is provided pursuant to the Privacy Act 1974 (5 U.S.C 552a). Our authority to collect this information is 37 U.S.C 403; 42 U.S.C 202 et seq.; and Executive Order 9397.

Purposes and Uses: The information you supply will be used to fulfill your request for voluntary State income tax withholding from your retired pay.

Effects of Nondisclosure: Disclosure of your Social Security Account Number (SSAN) is mandatory. The SSAN is requested for identification purposes. Failure to supply complete and accurate information may result in delays and/or denial of request.