Toll Free: 800-381-5111 Michigan.gov/PSRU Fax: 517-284-4416

Complete this form if you are adjusting a Detail 4 record with MEMBER'S NAME (LAST, FIRST, M.I.)			LAST 4 DIGITS OF SSN		
Complete this succount. ORS	Request for Adjustmosection with the wages that will determine the necessa	ent t Office of Retiremer ry adjustments with	the correct		
Personal Healt PAY PERIOD TO ADJUST	hcare Fund (PHF) employed PAY PERIOD BEGIN DATE (MM/DD/YYYY)	PAY PERIOD END D (MM/DD/YYYY)		AMOUNT OF WAGES TO ADD OR REMOVE	ADJUSTMENT REQUEST
PAY PERIOD 1:					☐ REMOVE WAGES ☐ ADD MISSING WAGES
PAY PERIOD 2:					□ REMOVE WAGES □ ADD MISSING WAGES
PAY PERIOD 3:					□ REMOVE WAGES □ ADD MISSING WAGES
PAY PERIOD 4:					□ REMOVE WAGES □ ADD MISSING WAGES
PAY PERIOD 5:					☐ REMOVE WAGES ☐ ADD MISSING WAGES
PAY PERIOD 6:					☐ REMOVE WAGES ☐ ADD MISSING WAGES
PAY PERIOD 7:					☐ REMOVE WAGES ☐ ADD MISSING WAGES
PAY PERIOD 8:					□ REMOVE WAGES □ ADD MISSING WAGES
PLEASE EXPLAIN	THE REASON FOR THE ABOVE AD.	JUSTMENT REQUEST.			
Section II –	Certification				
By my signatur	e I certify the above adjustme	nt request information	is correct to	o the best of my knowled	ge and belief.
REPORTING UNIT NAME		REPORTING UNIT NU	NUMBER REPORTING UNIT OFFICIAL'S TITLE		TITLE
REPORTING UNIT OFFICIAL'S CONTACT NUMBER		REPORTING UNIT OFFICAL'S SIGNATURE			

Mail your completed form and any attachments to: Office of Retirement Services, PO Box 30170, Lansing, MI 48090-7671

ORS will notify you when adjustments have been made to a member's account and they will reflect on a future pay cycle statement.

