Attachment 1 A

FY 2019 VERAs, VSIPs PROCESSING COSTS UNDER THE
FURTHER ADDITIONAL CONTINUING APPROPRIATIONS ACT, 2019 P.L. 116-5
REMITTANCE REPORT FOR FY 2019 VERAs

		Remittance Date:
Reporting Entity:	POC Name:	
POC Email address:	POC Phone Number:	FY 2019 Retirement Month:
Funds submitted by: (Indicate IPAC, EFT or CHECK) — IPAC / EFT / CHECK	FY 2019 VERAs	_____ (MM/YYYY)

Payroll Office Number: (Column 1)	Agency Location Code: (Column 2)	Number of Covered Employees (Column 3)	Amount Submitted Column 3 x $390.00
FERS			
TOTALS (A)			$
CSRS			
TOTALS (B)			$
AMOUNT SUBMITTED			$

(Must Equal A + B)

I certify to the best of my knowledge, the accuracy and completeness of this Remittance Report.

(To Be Reproduced Locally)
(Use additional forms if needed)

_____   _____
Signature   Name - Printed

Attachment 1 B

FY 2019 VERAs, VSIPs PROCESSING COSTS UNDER THE
FURTHER ADDITIONAL CONTINUING APPROPRIATIONS ACT, 2019 P.L. 116-5
REMITTANCE REPORT FOR FY 2019 VSIP

		Remittance Date:
Reporting Entity:	POC Name:	
POC Email address:	POC Phone Number:	FY 2019 Retirement Month:
Funds submitted by: (Indicate IPAC, EFT or CHECK)	IPAC / EFT / CHECK — FY 2019 VSIPs	_____ (MM/YYYY)

Payroll Office Number: (Column 1)	Agency Location Code: (Column 2)	Number of Covered Employees (Column 3)	Amount Submitted Column 3 x $390.00
FERS			
TOTALS (A)			$
CSRS			
TOTALS (B)			$
AMOUNT SUBMITTED			$

(Must Equal A + B)

I certify to the best of my knowledge, the accuracy and completeness of this Remittance Report.

(To Be Reproduced Locally)
(Use additional forms if needed)

_____   _____
Signature   Name - Printed

Attachment 1 C

FY 2019 VERAs, VSIPs PROCESSING COSTS UNDER THE
FURTHER ADDITIONAL CONTINUING APPROPRIATIONS ACT, 2019 P.L. 116-5
REMITTANCE REPORT FOR FY 2019 VERAs with VSIPs

		Remittance Date:
Reporting Entity:	POC Name:	
POC Email address:	POC Phone Number:	FY 2019 Retirement Month:
Funds submitted by:	IPAC	_____ (MM/YYYY)
	EFT — FY 2019 VERAs with VSIPs	
(Indicate IPAC, EFT or CHECK)	CHECK	

Payroll Office Number: (Column 1)	Agency Location Code: (Column 2)	Number of Covered Employees (Column 3)	Amount Submitted Column 3 x $390.00
FERS			
TOTALS (A)			$
CSRS			
TOTALS (B)			$
AMOUNT SUBMITTED			$

(Must Equal A + B)

(To Be Reproduced Locally)

(Use additional forms if needed)

I certify to the best of my knowledge, the accuracy and completeness of this Remittance Report.

_____   _____
Signature   Name - Printed