

Direct Deposit Authorization Agreement

INSTRUCTIONS: Before you submit this application please have a representative of your banking institution **verify your account number and bank transit/ABA routing number** or attach a blank check marked "VOID". Completed forms should be mailed to the **Fairfax County Retirement Systems Office**, 10680 Main Street, Suite 280, Fairfax, VA 22030.

Please Type or Print in Ink

Name of Retiree: _____ Social Security # (Last 4 Digits): _____

Address: _____

City, State, Zip: _____ Phone: _____

Account Number: _____ Type of Account: Checking Savings

Check here if this is a new address.

I authorize the County of Fairfax, Virginia to initiate credit entries to my account indicated above in the depository named below. I also authorize the County of Fairfax to draw drafts or to initiate debit entries on my account for the purpose of withdrawing money from my account, but solely in order to adjust an error resulting from a deposit or credit entry that has been made under this authorization in an amount that is not correct.

Since there is a slight possibility that my account will not be credited in a timely manner, I understand that I must check with my depository to verify that my account has in fact been credited before engaging in any financial transaction that is dependent on the existence of the credit entry.

This authority is to remain in effect until the County of Fairfax has received written notification from me of its termination in such time and in such manner as to afford the County of Fairfax a reasonable opportunity to act on it. I also understand that should my bank change any of its account or routing numbers I will have to submit a new form with the updated information to the Retirement Systems so the correct account will continue to be credited.

Benefit payments will be sent electronically to the account and routing number provided on the Direct Deposit Authorization. Please ensure accurate information is provided to ensure timely receipt of funds.

Retiree Signature: _____ Date: _____

To Be Verified By Banking Institution – OR attach a blank check marked "VOID"

This form must be signed by a bank representative before it can be processed **OR ATTACH A CHECK MARKED "VOID"**.

Name of Depository/Bank: _____

Address: _____

BK/TRANSIT/ABA Routing Number: _____ Account # _____

Financial Institution Certification: I confirm the transit/routing number and account number for the individual named above. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

Signature of Representative: _____ Date: _____ Phone: _____