

Secondary Direct Deposit Authorization Agreement

Please complete and return the form to **Fairfax County Retirement Systems** at 12015 Route 50, Suite 350, Fairfax, VA 22033 or fax it to 703-653-9543.

A copy of your driver's license, passport, or photo ID is REQUIRED if requesting a change to your existing banking information.

Please Type or Print in Ink

SECTION A: General Information

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

Mailing Address: _____ Phone: _____

City, State, Zip: _____

Email address: _____

Bank Name: _____ Account # _____

I elect to:

- Cancel existing secondary direct deposit.
- Change existing secondary direct deposit amount to \$ _____.
- Start a new secondary direct deposit for \$ _____ (Section B must be completed).

Benefit payments will be sent electronically to the account and routing number provided on the Direct Deposit Authorization Form. Please ensure accurate information is provided to ensure timely receipt of funds. Deposits can only be made to Domestic U.S. Banks

Retiree Signature: _____ Date: _____

SECTION B: New Direct Deposit Set-Up

I authorize the County of Fairfax, Virginia to initiate credit entries to my account indicated above in the depository named below. This includes my authorization to correct entries made in error. 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 submit a new form with the updated information to Retirement Systems so the correct account will continue to be credited.

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

Name of Depository/Bank: _____ Account Type: K Checking K Savings

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: _____