

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**, 12015 Lee Jackson Memorial Highway, Suite 350, Fairfax, VA 22033.

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip:
Social Security #:	Phone #:		
Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings			

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 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.

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: _____