

**TOWN OF DAVIE POLICE PENSION PLAN**

*C/O Precision Pension Administration, Inc.*

*13790 NW 4th Street, Suite 105*

*Sunrise, Florida 33325*

*Phone: 954.636.7170*

*Toll Free Fax: 866.769.0678*

AS PART OF OUR ONGOING EFFORT TO SECURELY HANDLE INFORMATION TRANSFERS, PLEASE REFRAIN FROM SENDING THIS DOCUMENT BACK VIA UNSECURED EMAIL.

OTHER ALTERNATIVES EXIST TO INCLUDE US MAIL, FAX (NUMBER CITED ABOVE), OR MAKE AN APPOINTMENT TO DROP OFF AT THE OFFICE.

LASTLY, ALSO, PLEASE USE LAST FOUR OF SOCIAL SECURITY NUMBER ONLY.

THANK YOU

# DIRECT DEPOSIT AGREEMENT

Plan Name \_\_\_\_\_ Account Number \_\_\_\_\_

**Instructions.** If you wish to have pension checks deposited electronically into your financial institution account, **please return this agreement to your former employer or pension fund office**, along with a voided check or voided savings deposit form. If your bank is not a member of the Automated Clearing House (ACH), your former employer or pension fund office will notify you, and this authorization will be canceled. All banking information must be approved and submitted by a Plan Representative.

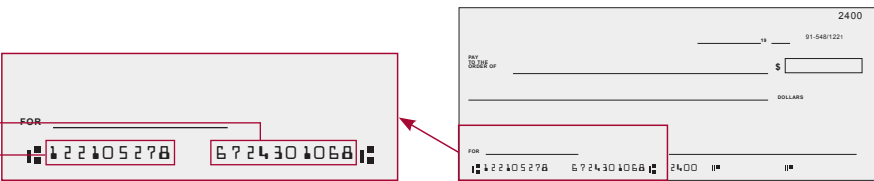
**1 PERSONAL INFORMATION**

Your Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**2 FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name \_\_\_\_\_ ABA Routing Number \_\_\_\_\_  
 Branch Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Account Number \_\_\_\_\_ Account Name \_\_\_\_\_

Account Number \_\_\_\_\_ ABA Routing Number \_\_\_\_\_



Account Type (check one):  
 Checking  Savings

**3 AUTHORIZATION**

I authorize Fiduciary Trust Company International to make all benefit payments to which I am entitled by direct deposit to the account designated above. To correct any overpayments made to my account during or after my lifetime, I hereby authorize and direct the financial institution designated above to debit my account and refund such overpayment to Fiduciary Trust Company International.

This authorization is to remain in force until I revoke it in writing or if Fiduciary Trust Company International terminates the direct deposit service. I will send all notices relating to direct deposit through my former employer or pension fund. I understand that I must allow reasonable time for any changes to be executed.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Plan Participant

\_\_\_\_\_  
 Print Name of Plan Participant

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Authorized Plan Representative

\_\_\_\_\_  
 Print Name of Authorized Plan Representative