



AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

RECIPIENT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

PLAN NAME (City retired from): _____

I hereby authorize SALEM TRUST COMPANY to initiate credit and debit entries or adjustments (if necessary for any credit entries made in error) to my checking or savings account as indicated below. SALEM TRUST COMPANY is only permitted to withdraw money from my account if an overpayment has been deposited into that account. Prior to making any deductions, SALEM TRUST COMPANY is required to notify me and the Board of Trustees of the above-referenced plan of the overpayment.

ACCOUNT INFORMATION (Check one)

_____ CHECKING (Attach voided check; deposit slips are not accepted)

_____ SAVINGS (Attach voided deposit slip)

_____ MONEY MARKET CHECKING (Attach voided check; check with your bank, most money markets are checking accounts, some are considered savings accounts)

_____ MONEY MARKET SAVINGS (Attach voided deposit slip; check with your bank, most money markets are checking accounts, some are considered savings accounts)

FINANCIAL INSTITUTION INFORMATION

ROUTING OR ABA NUMBER (first 9 digits): _____

ACCOUNT NUMBER: _____

BANK NAME: _____

PHONE NUMBER (Including area code): _____

This authorization is to remain in full force and effect until SALEM TRUST COMPANY has received notification from me of its termination, in such a manner as to afford SALEM TRUST COMPANY and my financial institution a reasonable opportunity to act upon my request. I hereby agree to hold SALEM TRUST COMPANY harmless from any loss resulting from following the above instructions.

If any payments are deposited to my account which I am not entitled to receive under said Plan, by reason of death prior to the date when such payments became due, then for myself, my heirs, executors and assigns, I agree to repay and refund the amount of any such overpayments. I hereby authorize and direct the financial institution named above to refund the amount of such overpayments to SALEM TRUST COMPANY and debit the amount from my account.

SIGNATURE: _____ DATE: _____

Your request will be processed promptly upon our receipt of your completed Direct Deposit Authorization

STATE OF

COUNTY OF

BEFORE ME, the undersigned authority, appeared before me _____ by means of ☐ physical presence
☐ online notarization and who is ☐ personally known to me or ☐ has produced _____ as identification,
and who did take an oath and, after being duly cautioned and sworn, deposes and says that he/ she has signed the foregoing
document for the reasons therein contained.

SWORN TO AND SUBSCRIBED before me this the _____ day of _____, _____.

Notary Public, State of Florida
At Large

My Commission Expires:

My Commission Number Is:

Return Completed Form to:

Resource Centers, LLC
4360 Northlake Boulevard Suite 206
Palm Beach Gardens, FL 33410
Fax: 561-624-3278 Email: ClientServices@ResourceCenters.com