WEST PALM BEACH POLICE PENSION FUND
OFFICE OF RETIREMENT
2100 North Florida Mango Road
West Palm Beach, Florida 33409

Phone: 561.471.0802 **FAX: 561.471.5027**

PLEASE REFRAIN SENDING BACK THIS DOCUMENT UNSECURED VIA E-MAIL. OTHER ALTERNATIVES US MAIL, FAX (NUMBER CITED ABOVE) OR DROP OFF AT THE OFFICE.

ALSO USE LAST 4 OF SSN ONLY.

THANK YOU!

Fiduciary Trust International

Direct Deposit Agreement

Plan Name WEST PALM BEACH POLICE PENSION FUND 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

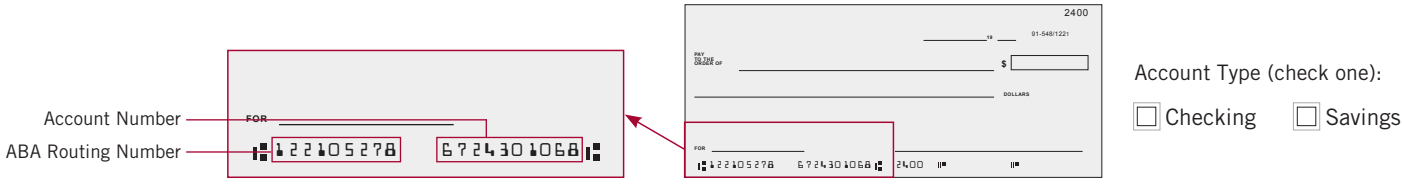
Home Address | City | State | Zip

2 FINANCIAL INSTITUTION INFORMATION

Financial Institution Name | ABA Routing Number

Branch Address | City | State | Zip

Account Number | Account Name



Account 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

FTCI PENDD 11/15