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

Fiduciary Trust International

Direct Deposit Agreement

Plan Name Town of Davie Police Pension Plan Account Number On file

Instructions. If you wish to have pension checks deposited electronically into your financial institution account, please return this agreement along with a voided check/savings deposit form to Plan Administrator. 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 the Plan Administrator.

1 PERSONAL INFORMATION

Participant Name

Social Security Number

Home Address

City

State

Zip

2 FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

ABA Routing Number

Account Number

Account Name

Account Type **(Must Select 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

FTI-NY PENDD 03/23