

OFFICE OF RETIREMENT
POLICE OFFICERS' RETIREMENT SYSTEM

**4205 Hollywood Boulevard, Suite 4
Hollywood, Florida 33021**

Telephone: (954) 967- 4395

Fax: (954) 967- 4387

Toll Free: (866) 738- 4776

**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 FOUR OF SOCIAL SECURITY ONLY

THANK YOU!

DIRECT DEPOSIT AGREEMENT

Plan Name HOLLYWOOD POLICE RETIREMENT SYSTEM 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.

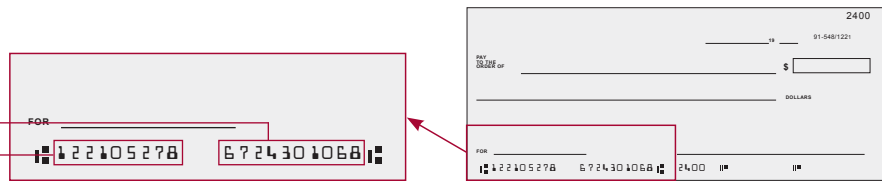
1 PERSONAL INFORMATION

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

DAVID M WILLIAMS

 Print Name of Authorized Plan Representative