



Direct Deposit Authorization

NOTICE

This form must be received by the 15th of the month for your monthly benefit payment to be directly deposited into your bank account by the end of the month.

YOUR INFORMATION

EMPLOYER NAME *			ACCOUNT NUMBER	
SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *	
MAILING ADDRESS *		CITY *	STATE *	ZIP *
EMAIL ADDRESS		HOME PHONE	MOBILE PHONE	

BANKING INFORMATION

FINANCIAL INSTITUTION *	ROUTING NUMBER *	ACCOUNT NUMBER *	<input type="checkbox"/> CHECKING *
			<input type="checkbox"/> SAVINGS *
MAILING ADDRESS	CITY	STATE	ZIP
PHONE NUMBER			

YOUR AUTHORIZATION

For the account referenced above, I authorize the Texas County & District Retirement System (TCDRS) to deposit my monthly benefit payments into my bank account. I also authorize TCDRS to make adjustments to my account to correct any transactions made in error. This authority shall remain in effect until I notify TCDRS to discontinue this payment method. I have requested the Texas County & District Retirement System to directly deposit my benefit payments by electronic transfer to the above referenced account and I hereby authorize the financial institution named above to disclose to the Texas County & District Retirement System at any time my address and contact information, and to disclose the names and addresses of all joint owners, signatories, beneficiaries or other persons associated with the above referenced account if I pass away. A photocopy of this signed form shall be sufficient authorization for such disclosure.

SIGNATURE X	DATE
----------------	------

Print Form

Reset Form

* REQUIRED FIELDS

Any corrections or whiteouts must be initialed.