

# Direct Deposit Authorization

## Retirement Systems of Alabama



P.O. Box 302150  
Montgomery, Alabama 36130-2150  
334-517-7000 or 877-517-0020  
www.rsa-al.gov

The retiree or beneficiary of a deceased retiree must complete the front page of this form. Then take or mail the form to your financial institution so they may verify the information on the front, **complete the information on the reverse side**, and agree to the Master Agreement.

### Benefit Recipient Information

Social Security Number \_\_\_\_\_

Benefit Recipient (Please check one):

- Retiree
- Beneficiary of Deceased Retiree/Member

Name \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone No. \_\_\_\_\_

\_\_\_\_\_

Email Address \_\_\_\_\_

\_\_\_\_\_

Indicate the system(s) from which you would like your benefit(s) direct deposited.

- Teachers' Retirement System
- Employees' Retirement System
- PEIRAF
- Judicial Retirement Fund
- RSA-1 (Annual or Monthly Distribution Only)

### Joint Financial Institution Account Holder's Certification:

I agree to notify the Retirement Systems of Alabama (RSA) immediately of the death of the recipient of the retirement benefits being deposited to this joint financial institution account, and to return all payments to the RSA that are deposited to this account after said death. The RSA will determine and pay any survivor benefits. The RSA is authorized to make necessary debit entries to this joint financial institution account for any credits that were made in error.

Name(s) of Joint Financial Institution Account Holder(s)

Signature(s) of Joint Financial Institution Account Holder(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

### Benefit Recipient Certification:

Each benefit payment is to be credited to my account at the financial institution specified on the reverse side of this form and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such payments.

If my death occurs prior to the due date of any payment made by the RSA in compliance with this request or if adjustments are required for any credit entries to my account, I authorize the RSA to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within 30 days of receipt of written notice by the RSA.

I authorize my payment to be sent to the financial institution named on the reverse side of this form to be deposited to the designated account.

Signature of Benefit Recipient \_\_\_\_\_ Date \_\_\_\_\_

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**Financial Institution Information (to be completed by a representative of the financial institution)**

Name of Benefit Recipient \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Depositor Account No. \_\_\_\_\_ Bank Routing No. \_\_\_\_\_

Name of Financial Institution \_\_\_\_\_ Type of Account:  Checking  
 Savings

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Name(s) of Person(s) on this Account: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Financial Institution Certification and MASTER AGREEMENT:**

In accordance with the provisions of Section 3.6.4 of the 2012 National Automated Clearing House Association (NACHA) Operating Rules and Guidelines, both the Retirement Systems of Alabama (RSA), as the Originator, and the above named Financial Institution consider the following to be the Master Agreement, as defined by the NACHA Operating Rules and Guidelines, and agree that it is to be applicable to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts with the Financial Institution.

In consideration of the RSA making benefit payments in accordance with this Direct Deposit Authorization without requiring proof that the retiree/beneficiary identified on this form is alive on the date on which such benefits are paid and are credited to his or her account, the Financial Institution agrees to repay and refund to the RSA, on demand, the full amount of any payments made to and received by the Financial Institution after the date of death of the benefit recipient, regardless of whether the account listed on this Direct Deposit Authorization contains sufficient funds for the refund. The Financial Institution further agrees to accept the certification of the RSA as to the date of death of such payee as sufficient evidence in accordance with Section 2.10 of the 2012 NACHA Operating Rules and Guidelines.

I, the undersigned, confirm that the identity of the above named retiree/beneficiary, account number, and type are true and accurate. As the representative of the above named Financial Institution, I certify that the Financial Institution agrees to receive and deposit the identified payments in accordance with the Master Agreement and pursuant to Section 3.6.4 of the 2012 NACHA Operating Rules and Guidelines, and that the Master Agreement is applicable to all payments sent by the RSA to the Financial Institution for the benefit of the retiree/beneficiary.

Name of Representative \_\_\_\_\_

Signature of Representative \_\_\_\_\_ Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

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<p><b>Note:</b> Direct Deposit Authorization forms that are processed after the 14th of each month will become effective the following month.</p>
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**Please return completed form to:**

The Retirement Systems of Alabama  
P.O. Box 302150  
Montgomery, Alabama 36130-2150