



Submit completed form to:
County Employees' Retirement Fund
 2121 Schotthill Woods Drive
 Jefferson City, MO 65101
 Toll Free: 877-632-2373
 Fax: 573-761-4404

Version 5.6

**FORM EFT
 ELECTRONIC FUNDS TRANSFER**

Direct Deposit Authorization Form

IMPORTANT: A voided check must be returned with this form. If using a savings account, documentation from your financial institution must be provided. If submitting a deposit slip, please verify the routing number with your financial institution.

PAYEE INFORMATION

Social Security Number _____ - _____ E-mail Address _____
 First Name _____ Initial _____ Last Name _____ Suffix _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (_____) _____ Cell Phone (_____) _____

REQUIRED SIGNATURES – See Below

I hereby authorize the County Employees' Retirement Fund's affiliated financial institution to initiate credits and debits relative to pension payment, if necessary, to my bank account listed below. This authorization hereby revokes all prior payment directions given to CERF. This authorization is to remain in full force and effect until CERF has received written notification from me or anyone with legal authority to act on my behalf. I understand that I may only change my information by notifying CERF in the manner specified herein and my information cannot be changed by contacting the financial institution. I also understand that CERF or its affiliated financial institution will not be liable for any error or delay in processing a transfer by another financial institution or its processing agent. Furthermore, I also permit the release by my current or any future receiving depository financial institution to CERF of my current address, names and current addresses of all persons listed on the account, and names and current addresses of all beneficiaries on the account, including, but not limited to those listed as "payable on death" or "transfer on death."

Signature of Payee _____ **Date** _____

Print Name of Joint Account Owner (in addition to payee)

Print Name of Joint Account Owner (in addition to payee)

First Name _____ Initial _____ Last Name _____

First Name _____ Initial _____ Last Name _____

Signature of Joint Account Owner _____ **Date** _____

Signature of Joint Account Owner _____ **Date** _____

FINANCIAL INSTITUTION INFORMATION

Bank's Name _____
 Address _____ City _____ State _____ Zip _____
 Routing Number _____ Account Number _____ Checking Account Savings Account

REQUIRED FINANCIAL INSTITUTION SIGNATURE – See Below

By signing below, the undersigned financial institution understands these payments will terminate with the last payment issued in the month of death of the payee and agrees to return to CERF the full amount of payments received after the last payment issued in the month of death of the named payee.

Printed Name of Financial Institution Official

Title

Phone Number

Signature of Financial Institution Official _____ **Date** _____