

Montgomery County Long Term Disability Plan (LTD2)

Electronic Direct Deposit Authorization Form – Benefit Payments

I hereby make the following requests and authorizations relating to my benefit payments from the Montgomery County Long Term Disability Plan: (1) I request and authorize you to initiate credit entries to my Account indicated below; (2) I request and authorize you to initiate debit entries and adjustments for any credit entries made in error to the Account; and (3) I request and authorize the Financial Institution named below to credit and/or debit any such entries to the Account.

1. **Participant Name** _____
(Full Name)

2. **Social Security Number** _____

3. **Participant Home Address** _____

(City, State and Zip Code)

4. **Daytime Phone Number** _____

5. **Financial Institution's Name** _____

6. **Account Type** Checking Saving Other _____

7. **Basic Information** _____ _____
(Bank Routing Number) *(Account Number)*

Please attach a VOIDED CHECK (For checking account only). This check must be imprinted with the name and address. We cannot accept starter checks, deposit slips or computer generated Direct Deposit Authorization forms from your bank. If the type of bank account elected is other than checking, or if you only have starter checks, then you must include a letter from the bank, or a bank statement, signed by a bank official that includes your name, address, bank account number and routing number.

I certify that the above account is located in the U.S., bears my name and that I am an unrestricted and authorized signor on the account. I authorize Montgomery County Government (MCG) and the bank indicated above to deposit the assigned amount of my benefit and any reimbursements automatically into my savings or checking account each month. If money to which I am not entitled is deposited into my account, I understand that MCG has the authority to direct the bank to return those funds. I have read the information contained in this form and my signature confirms my understanding..

Participant Signature: _____

Date: _____

PLEASE RETURN THE COMPLETED FORM, ALONG WITH A COPY OF A VOIDED CHECK OR OTHER DOCUMENTATION AS DESCRIBED ABOVE, TO:

**Montgomery County Employee Retirement Plans
101 Monroe Street, 6th floor
Rockville, MD 20850
Phone: (240) 777-8230 Fax: (240) 306-1389**

Please keep a copy of this form for your records