GRE-54 (1/11)

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395
Fax: (518) 447-4749

OFFICE SERVICES ONLY

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

☐ *Please check this box if any of this direct deposit will go directly to a foreign bank or if the entire amount is forwarded from a domestic bank to a foreign bank.*

Please complete the information requested below and make a copy of this form for your records.

EmplID #

Social Security Number – –

First Name **MI** **Last Name**

Street Address

Street Address

City **State** **Zip Code** –

Phone Number ( ) –

If this is a change of address, please give effective date: / /
Month Day Year

Please indicate the type(s) of payments you are receiving from this system:

☐ Retiree
☐ Beneficiary of a retiree
☐ Alternate payee under a Domestic Relations Order

ACCOUNT INFORMATION

Education Law §524 states that a member's benefit is unassignable to an account that is in the title of a Trust.

The following bank information is or will be used to transmit your retirement payments directly to your bank account. The bank ABA # / Routing # is usually the first 9 digits on the bottom of your check, or this number can be obtained by contacting your bank. If you have any questions regarding your ABA # or account number, contact your financial institution.

BANK NAME

BANK TELEPHONE NUMBER ( ) –

BANK ABA # / ROUTING # (ACH format - 9 digits)

ACCOUNT #

ACCOUNT TYPE *(Please check one)* **CHECKING** ☐ **SAVINGS** ☐ **Note:** Deposits can be made to money market accounts

I authorize NYSTRS to automatically deposit any benefit payable to me in the foregoing account, or in any future account hereafter communicated by me to NYSTRS in writing, which future account(s) shall be subject to the terms of this Direct Deposit Agreement. I understand that I may cancel this authorization by submitting written notification to NYSTRS.

I understand NYSTRS may cease to honor this authorization or may change the terms upon notice to me. I also understand that NYSTRS shall not be responsible for any delay resulting from inaccurate information supplied to NYSTRS.

I understand I am entitled to my benefit payment until the date of my death. I authorize NYSTRS to recover any overpayment from my financial institution.

SIGNATURE: Month / Day / Year