GRE-54 (5/08)

OFFICE SERVICES ONLY

**NEW YORK STATE TEACHERS' RETIREMENT SYSTEM**
**10 Corporate Woods Drive, Albany, NY 12211-2395**

# DIRECT DEPOSIT AUTHORIZATION AGREEMENT

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

## RETIREE INFORMATION

**EmplID #**

**Social Security Number** ___ - ___ - ____

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

**Street Address**

**Street Address**

**City** | **State** | **Zip Code** ____ - ____

**Home Telephone 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 ____