

## DIRECT DEPOSIT SIGN-UP FORM

### DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

### SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (last, first, middle initial)		D TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
ADDRESS (street, route, P.O. Box, APO/FPO)		E DEPOSITOR ACCOUNT NUMBER	
CITY	STATE	F TYPE OF PAYMENT (Check only one)	
TELEPHONE NUMBER	ZIP CODE	<input type="checkbox"/> Social Security <input type="checkbox"/> Fed. Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active _____ <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. _____ <input type="checkbox"/> Civil Service Retirement (OPM) <input type="checkbox"/> Mil. Survivor _____ <input type="checkbox"/> VA Compensation or Pension <input type="checkbox"/> Other _____ (specify)	
B NAME OF PERSON(S) ENTITLED TO PAYMENT		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable)	
C CLAIM OR PAYROLL ID NUMBER		TYPE	AMOUNT
Prefix	Suffix	JOINT ACCOUNT HOLDERS' CERTIFICATION (optional)	
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

### SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

Government Agency Name: Prince George's County Government	Government Agency Address: Pensions & Investments Division 1400 McCormick Drive, Room #110 Largo, MD 20774
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### SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION		ROUTING NUMBER		CHECK DIGIT
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/>
DEPOSITOR ACCOUNT TITLE				
FINANCIAL INSTITUTION CERTIFICATION				
I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.				
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE	

Financial institutions should refer to the GREEN BOOK for further instructions.  
 THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

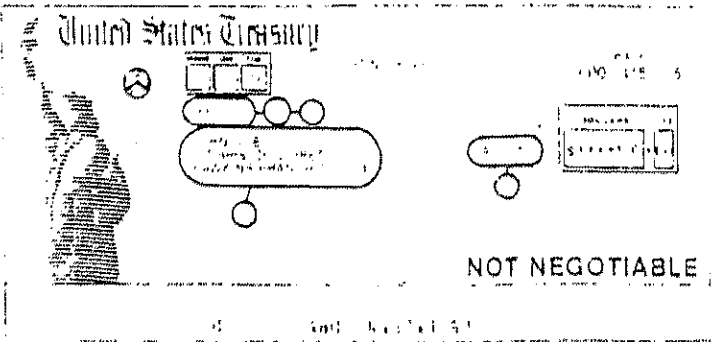
PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

**INFORMATION FOUND ON CHECKS**

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.



**SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS**

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

**CANCELLATION**

The authorization represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing notice 30 days in advance of the cancellation date. The recipient must notify the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

**CHANGING RECEIVING FINANCIAL INSTITUTIONS**

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1109A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

**FALSE STATEMENTS OR FRAUDULENT CLAIMS**

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

**PRINCE GEORGE'S COUNTY MARYLAND**

OFFICE OF FINANCE – ACCOUNTING DIVISION

14741 GOV. ODEN BOWIE DRIVE, SUITE 3151

UPPER MARLBORO, MD 20772

Voice: 301.952.5481 Fax: 301.952.3529 Email: pgeap@co.pg.md.us

**AUTHORIZATION FOR ELECTRONIC FUNDS DISBURSEMENT**

**PRIVACY ACT STATEMENT**

The following information is being provided to comply with the Privacy Act of 1974 (P.L. 93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 CFR 210. This information will be used to start/stop payment data by electronic means to the referenced financial institution. Failure to provide correct or complete information may delay or prevent the receipt of payments through the Automated Clearing House Payment System. (April 2004)

**VENDOR/PAYEE INFORMATION**

Action: Start \_\_\_\_\_ Stop \_\_\_\_\_ Federal TIN/SSN \_\_\_\_\_

Legal Name \_\_\_\_\_ Business Name (if different) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Remittance Address (if different) \_\_\_\_\_

Contact \_\_\_\_\_ Title \_\_\_\_\_

Voice \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

**FINANCIAL INSTITUTION**

Name of Bank \_\_\_\_\_ Account Title \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Account Number \_\_\_\_\_ Checking \_\_\_\_\_ Savings \_\_\_\_\_

Nine-digit Routing No: \_\_\_\_\_

**CONDITIONS AND AUTHORIZATION**

I acknowledge that this form has been completed to the best of my knowledge. I understand that in the event of an erroneous payment, the County reserves the right to reverse a transfer and further understand that failure to provide accurate information could result in a forfeit of this payment method. I certify that I am a multiple payment vendor of at least five payments and will provide the County with my vendor number on all correspondence. I must communicate any changes in the financial institution(s) or account(s) to the County within five business days of the new information becoming effective. I understand that this payment method is governed by County policy that may periodically change without prior notice. I hereby authorize Prince George's County to electronically transfer payments due to the referenced business enterprise for goods or services rendered to the County.

Officer Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICIAL USE ONLY**

Pay Entity \_\_\_\_\_ Vendor No. \_\_\_\_\_ Processor \_\_\_\_\_ Date \_\_\_\_\_