Municipality of Anchorage

RETIREE MEDICAL FUNDING PROGRAM TRUST FOR POLICE OFFICERS AND FIREFIGHTERS

Direct Deposit Agreement Form

Authorization Agreement

I (we) hereby authorize Municipality of Anchorage Retiree Medical Funding Program for Police Officers and Firefighters to initiate automatic deposits to my account at the financial institution named below. I (we) hereby authorize Municipality of Anchorage Retiree Medical Funding Program for Police Officers and Firefighters to debit my (our) account for amounts in error not to exceed the original credit.

Further, I agree not to hold Municipality of Anchorage Retiree Medical Funding Program for Police Officers and Firefighters responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Municipality of Anchorage Retiree Medical Funding Program Trust for Police Officers and Firefighters receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Trust.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Checking ☐ Savings ☐

Signature

Authorized Signature (Primary): _____ **Date:** _____

Authorized Signature (Joint): _____ **Date:** _____