

ACH DIRECT DEPOSIT AUTHORIZATION

Instructions for completing the form are on the back.

PLEASE PRINT ALL INFORMATION CLEARLY			
Recipient's Name →		Street, Route PO Box →	
Telephone Number →		City, State Zip Code →	

MEMBER ACKNOWLEDGEMENT

I authorize the Employees' Retirement System (ERS) and the Financial Institution listed below to initiate deposits of funds to which I am entitled automatically to my account. This supersedes any previous instructions until canceled by me in writing. If funds to which I am not entitled are deposited to my account, (including any benefit payment made on or after my death), I authorize you to direct the Financial Institution to immediately refund any overpayments to the ERS. If the funds remaining in the account are not sufficient to permit the Financial Institution to fully refund overpayments, I authorize and direct the Financial Institution to provide to the ERS all information related to the account, including transactions since the first of the month in which my death occurs, and the names and addresses of all joint account holders and any individuals authorized to withdraw funds from the designated account.

I agree that jurisdiction over any collection actions related to the recovery of any funds transferred to the designated account by the ERS will be exclusively in the courts of the State of Wisconsin.

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint Account Holders should **immediately** advise both the ERS and the Financial Institution of the death of a recipient. Funds deposited after the date of death or ineligibility are to be returned to the ERS. The ERS will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

ACCOUNT HOLDER'S CERTIFICATION

I certify that I have read and understood both sides of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS. I understand that my name must be on the account. ERS will not directly deposit benefit payments to an account of another person or institution, including trusts or nursing care facilities.

Recipient's Signature:	Date	Soc. Sec. # _____ - ____ - _____
Joint Account Holder's Signature:	Date	Soc. Sec. # _____ - ____ - _____

————— Recipient: Do not write below this line – This is to be completed by the Financial Institution —————

PLEASE PRINT ALL INFORMATION CLEARLY AND CONFIRM ITS ACCURACY PRIOR TO SUBMISSION	
Account to be credited: Checking Account <input type="checkbox"/> or Savings Account <input type="checkbox"/>	Account Number Information ↓ <div style="border: 1px solid black; width: 100%; height: 20px; display: flex; justify-content: space-between;"> [] [] </div>
Name and Address of Financial Institution	Routing Number ↓ <div style="border: 1px solid black; width: 100%; height: 20px; display: flex; justify-content: space-between;"> [] [] </div>
Name on Account	

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.

Print or type Representative's Name	Signature of Representative	Telephone Number	Date
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Instructions for completing the ACH Direct Deposit Authorization form.

1. Please complete all recipient information on the reverse side of this form including signature, date and social security number. Read all terms and conditions appearing below.
2. Take this form to your financial institution and have them fill in the lower portion.
3. If this form is **received before the 19th** of the current month, your benefit will be deposited into the account identified on the reverse side. **ERS advises its recipients not to close existing accounts until they are able to confirm that direct deposits have been successfully changed to a new account.**
4. Please inform this office in writing **whenever** your **address** or your **account** is changing.
5. Give the **canary** copy to your financial institution; retain the **pink** copy for your records. If accessing this form from the internet, please photocopy the completed form for these purposes and be sure to print the terms and conditions page.
6. Return the **original white** copy to: **Employees' Retirement System, City of Milwaukee, 789 N Water St, Suite 300, Milwaukee WI 53202.**
7. Due to the high volume of forms received each month, ERS cannot confirm by telephone the receipt of this form. Please enclose a stamped, self-addressed envelope if you wish to receive confirmation that this form was received by ERS.

Terms and Conditions

The Employees' Retirement System (ERS) has entered into an agreement with an Originating Depository Financial Institution (ODFI) pursuant to which ERS will, on or before the end of each month, deposit with the ODFI funds which the ODFI will, in turn, through a Clearing House, route to Receiving Depository Financial Institutions (RDFI) for deposit into recipient's designated account. Such processing is governed by rules established by the National Automated Clearing House Association (ACH Operating Rules). This is the sole agreement between ERS and recipients concerning the subject matter hereof. Recipient releases and holds ERS harmless from, and against any losses, liability, damages, claims, actions, or expenses (including reasonable attorney fees), that the recipient may suffer or incur, due (directly or indirectly), to ERS's reliance on any information the recipient or Financial Institution as provided herein, or OFDI's, RFDI's or Clearing House's negligent or willful acts or omissions, or failure to act in accordance with ACH Operating Rules, or any breach by the OFDI of its contractual obligations to the ERS. The ERS is not responsible for any problems that may be caused by any ACH affiliate or the ACH Clearing House. Recipient agrees to indemnify ERS from, and against any loss, liability, damage, claim, action, or expense (including reasonable attorney fees) the ERS may suffer or incur due directly or indirectly to any breach by recipient of its obligations hereunder, or any incorrect information which recipient or Financial Institution furnishes hereunder.

1. The Financial Institution the recipient designates must be an ACH network affiliate capable of receiving direct deposits. If the recipient uses an account that is "payable through" another financial institution, it could result in processing delays since that institution may not be a direct ACH affiliate.
2. Recipient understands that if its designated Financial Institution is not located in Wisconsin, there may be delays such that receiving the direct deposit at the end of the month might not be possible. ERS shall not be responsible for delays under these circumstances.
3. Recipient understands that his or her name must be on the account. ERS will not directly deposit benefit payments to an account of another person or institution, including trusts or nursing care facilities.
4. If ERS becomes unable to deposit or timely deposit to the recipient's designated account through no fault of its own, the ERS may issue a check to the recipient rather than follow this agreement, and ERS shall not be responsible for any delay associated with such. In the unlikely event ERS experiences problems with processing direct deposit information in the system; ERS may issue a check until such time as the problem is corrected.
5. Recipient understands that only net pay will be deposited. All applicable deductions from gross pay will continue to be deducted subject to the amount of gross pay available for distribution.
6. Recipient understands that closing a designated account without timely notifying ERS will result in a delay in receiving the monthly benefit and that it is best to establish a new designated account prior to closing the previous one.