



**Seattle Firefighters  
Pension Board**

**Return completed form by mail or email:**  
Seattle Firefighters Pension Board  
2200 6th Avenue, Suite 820 Seattle, WA 98121-1822  
Email: seattlefirepension@seattle.gov  
Phone: 206-625-4355

## **AUTHORIZATION FOR DIRECT DEPOSIT**

**Section A: To be completed by payee, spouse or POA – Please Print**

Please select one or both boxes below to indicate the elections you would like to receive as a direct deposit:

**Medical Reimbursements**

**Pension Payments**

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**Payee First and Last Name**

I, \_\_\_\_\_, hereby authorize and request the Seattle Firefighters Pension Board to process all requested medical and/or retirement benefits, after authorized deductions, to the designated financial institution for deposit. The designated financial institution to provide information to Seattle Firefighters Pension Board regarding address changes and account information to ensure proper and timely processing of deposit transactions. The designated financial institution to refund to the Seattle Firefighters Pension Board any overpayments to my account made after my death or payments made in error.

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**Mailing address (number, street, city, state and zip code)**

**Phone Number:**

**Cell**

**Home**

**POA**

**Email**

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**Signature of Payee or POA**

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**Date**

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**Section B: Attach a voided check or have a financial institution fill out the information below:**

We hereby agree to receive and deposit sums for the payee named herein, in accordance with conditions established by the Seattle Firefighters Pension Board. We further agree to refund the Seattle Firefighters Pension Board any payments received in accordance with this agreement, which were paid in error or to which the payee was not entitled by reason of errors or his/her death prior to the dates of such payment(s).

**Name of Financial Institution**

**Phone** \_\_\_\_\_

**Checking**  **Savings** \_\_\_\_\_

**Transit/Routing Number**

**Account Number**

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**Branch Address (number, street, city, state and zip)**

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**Financial Institution Authorized Signature**

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**Date**