

DIRECT DEPOSIT FOR MONTHLY BENEFIT
UCRS 160 (R9/23) University of California Human Resources

Send completed form to:
UC Retirement Administration Service Center
P.O. Box 24570
Oakland, CA 94623-1570
Fax: 800-792-5178
retirementatyourservice.ucop.edu

Use this form to begin, change or cancel the electronic deposit of your monthly benefit. There may be a waiting period before your direct deposit change takes effect, determined by monthly processing deadlines. Please note, UC rules do not permit direct deposit of UCRP payments to banks outside the United States.

PERSONAL INFORMATION (Please complete entire section)		
NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	DAYTIME PHONE ()
MAILING ADDRESS (Number, Street)	CHANGE MY ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO	BENEFIT PAYMENT TYPE (Check one) <input type="checkbox"/> UCRP <input type="checkbox"/> UC PERS VERIP <input type="checkbox"/> UC 415(m)
(City, State, ZIP, Country)	STATUS (Check all that apply) <input type="checkbox"/> RETIRED / DISABLED <input type="checkbox"/> OTHER (NON-MEMBER) <input type="checkbox"/> SURVIVOR / CONTINGENT ANNUITANT	

ACTION

Action (check one):

☐ New enrollment ☐ Change my account. My current account will remain open until my new account is in effect.

☐ Cancel direct deposit ☐ Change my account. I have closed my account. Send my future checks to my mailing address until my new account is in effect.

A. Primary Account

Account type for new enrollment or direct deposit change (check one):

☐ Savings account ☐ Trust account (Must be grantor-type trust; tax I.D. number must be payee's SSN) check one box below:

☐ Checking account ☐ Trust savings account

☐ Trust checking account

☐ Check, if you wish to deposit your monthly benefit into multiple accounts. Indicate the percentage _____ % for the account listed in A and complete B. Additional Account to total 100%.

For completion by payee—You must attach a voided printed check (not necessary for savings). Do not attach a deposit slip.

NAME OF FINANCIAL INSTITUTION	ACCOUNT NUMBER
BRANCH NAME AND ADDRESS	BRANCH TELEPHONE NUMBER ()
(City, State, ZIP)	

For completion by financial institution—(Not necessary if you attach a voided printed check) For Savings account, complete this section.

NAME OF FINANCIAL INSTITUTION	ACCOUNT NUMBER (Show the number exactly as required for direct deposit)
BRANCH NAME AND ADDRESS	BRANCH TELEPHONE NUMBER BANK TRANSIT ROUTING NUMBER

I confirm the identity of the above-named payee and the account number. As a representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above.

SIGNATURE OF REPRESENTATIVE	PRINT / TYPE REPRESENTATIVE'S NAME	DATE
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B. Additional Account

Account type for new enrollment or direct deposit change (check one):

- ☐ Savings account* ☐ Trust account (Must be grantor-type trust; tax I.D. number must be payee's SSN) check one box below:
☐ Checking account ☐ Trust savings account
☐ Trust checking account

Indicate the percentage _____ % for the account listed below to total 100%. If your percentages do not add up to 100%, the balance will be assigned to the primary account.

For completion by payee—You must attach a voided printed check (not necessary for savings). Do not attach a deposit slip.

NAME OF FINANCIAL INSTITUTION	ACCOUNT NUMBER
BRANCH NAME AND ADDRESS	BRANCH TELEPHONE NUMBER
(City, State, ZIP)	()

For completion by financial institution—(Not necessary if you attach a voided printed check) *For Savings account, must complete this section.

NAME OF FINANCIAL INSTITUTION	ACCOUNT NUMBER (Show the number exactly as required for direct deposit)	
BRANCH NAME AND ADDRESS	BRANCH TELEPHONE NUMBER	BANK TRANSIT ROUTING NUMBER

I confirm the identity of the above-named payee and the account number. As a representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above.

SIGNATURE OF REPRESENTATIVE	PRINT / TYPE REPRESENTATIVE'S NAME	DATE
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CERTIFICATION AND AUTHORIZATION (Signature(s) required)

I certify that I am entitled to the payment identified above, and that I have read and understand the information and instructions on this form. In signing this form, I authorize my payments to be sent to my financial institution(s) and deposited to the account(s) I have designated. If any account designated is a trust account, I also certify that the account tax I.D. number is my Social Security number. I understand that any overpayment of benefits shall be returned to the Plan Administrator immediately on demand and any recipient of the overpayment shall hold such amounts in trust for the Plan Administrator. I authorize the University of California to debit my account for any amounts transmitted in error or after my death. If the funds have been withdrawn following my date of death, I authorize my financial institution to release to UC the name and address of the person(s) responsible for withdrawing the funds. **I understand that if deposits are being made to a joint account the other account holder must sign the "Joint Account Holder's Certification" (below).** I further agree that if the account specified above becomes a joint account (or if the joint account holder changes), I must complete a new form. I understand that this authorization will remain in effect until I cancel it by submitting a new form.

SIGNATURE OF PAYEE	DATE
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JOINT ACCOUNT HOLDER'S CERTIFICATION

I certify that I have read this form. If the payee named at above dies, I agree to refund to the University any payments deposited in our account that he or she was not entitled to receive. **(Please notify UCRS of the death of the UCRS payee.)**

SIGNATURE OF JOINT ACCOUNT HOLDER	DATE
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PLEASE KEEP A COPY OF THE FORM FOR YOUR RECORDS.

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be transmitted to the federal and state governments when required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Vice President—University of California Human Resources, 1111 Franklin Street, Oakland, CA 94607-5200.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. The University's record keeping system was established prior to January 1, 1975 under the authority of The Regents of the University of California under Article IX, Section 9 of the California Constitution. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011, 6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.