



CITY OF RICHMOND
MEDICAL REIMBURSEMENT
AUTOMATIC CHECK DEPOSIT REQUEST

NAME: _____
Last First MI

SOCIAL SECURITY NUMBER: XXX – XX - _____

CHECKING (*attach a voided check*)

SAVINGS (*required printout from bank institution displaying name of bank, routing and account number*)

I hereby authorize the City of Richmond to deposit my medical reimbursement check into my checking account and if necessary to make any adjustments or corrections to my checking account for any deposits made to my account in error. This authorization shall remain in full effect until I notify the City in writing of its termination. **I have attached a voided check** showing the bank name and account number into which the deposit should be made. The voided check will be used by the City of Richmond Finance Department in preparing the necessary form to complete the automatic deposit of my medical reimbursement.

The city will provide a payment advice to the retiree at or around the date of each such deposit. Deposits will be made monthly by the 10th of each month.

Signature

Date