



**ACH Authorization Agreement
Direct Payments**

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Company: **FSM Social Security Administration**

I / We hereby authorize **FSM Social Security Administration**, hereinafter called COMPANY, to initiate Debit Entries to my/our Checking Account Savings Account (select one) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I / We acknowledge that the origination of ACH transactions to my /our account must comply with the provisions of U.S. law.

Depository (Name of Your Bank)

Bank Name/ Branch: _____
Street / P.O. Box _____ City: _____ State: _____ Zip: _____
Routing Number: _____ Account Number: _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

The debit to my / our Checking Account Saving Account (select one) will be on the 10th day following the end of every calendar quarter beginning, (Check one) 3/31 6/30 9/30 12/31

AMOUNT \$ 187.50

AMOUNT IN WORDS: One Hundred Eighty Seven Dollars & 50/100 Only

Name(s): _____ SS Number: _____
(Please print)

Mailing Address: _____

State Citizenship: Chuuk Pohnpei Kosrae Yap

Working Not Working

Employer's Name _____

Employer's Address _____

Signature: _____ Date: _____

Note: All written debit authorizations MUST provide that the receiver may revoke the authorization only by notifying the Originator in the manner specified in the authorization.

Please return to:
FSM Social Security Administration
P.O. Box L
Kolonias, Pohnpei
FM 96941

Call: (691)320-2708/2707/2706
Fax: (691)320-2607
E-Mail: fsmssa@mail.fm



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