



**MONTANA  
TEACHERS' RETIREMENT SYSTEM**

1500 E 6TH AVE  
PO BOX 200139  
HELENA MT 59620-0139  
www.trs.mt.gov  
406-444-3134  
1-866-600-4045

*TRS Office Use Only*

**AGREEMENT FOR ELECTRONIC FUNDS TRANSFER  
AUTOMATED CLEARING HOUSE DEBIT AUTHORIZATION**

PLEASE TYPE OR PRINT LEGIBLY IN DARK INK.

\_\_\_\_\_  
Employer's Printed Name

\_\_\_\_\_  
Employer's Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code)

\_\_\_\_\_  
TRS Six-Digit Employer Number

The employer hereby authorizes the Montana Teachers' Retirement System (TRS) to collect payments for employee and employer contributions due to the TRS by Electronic Funds Transfer (EFT) Automated Clearing House Debit (ACH Debit). The employer certifies that they have selected the following depository financial institution and directs that all such EFT's be made as provided below.

\_\_\_\_\_  
Depository Financial Institution's Name

\_\_\_\_\_  
Area Code and Telephone Number

\_\_\_\_\_  
Depository Financial Institution's Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code)

\_\_\_\_\_  
Depository Financial Institution's Transit Routing Number

\_\_\_\_\_  
Account Number for ACH Debit

\_\_\_\_\_  
Account Holder's Federal Tax ID

Indicate Type of Account  
 Checking       Savings

\_\_\_\_\_  
Employer's EFT Contact Person's Name

\_\_\_\_\_  
Employer's EFT Contact Person's E-Mail Address

\_\_\_\_\_  
Area Code and Telephone Number

The TRS will transfer funds from the employer's account to the State of Montana within five calendar days from the date the wages and contribution report is submitted. The transfer of funds represents the amount owed to the TRS as stated by the employer on the wages and contribution report.

The employer will give written notice ten days in advance to the TRS of any changes in the depository financial institution information or to request other payment arrangements.

When properly executed, this agreement will become effective within ten days after receipt by the TRS.

\_\_\_\_\_  
Certifying Officer's Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Certifying Officer's Signature

\_\_\_\_\_  
Date

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,  
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST.