



**DEPARTMENT OF FINANCIAL SERVICES**

***Division of Unclaimed Property***

**APPLICATION FOR REGISTRATION AS AN  
UNCLAIMED PROPERTY CLAIMANT REPRESENTATIVE  
FLORIDA PRIVATE INVESTIGATOR**

(TYPE OR PRINT)

1. The Business Name, Agency License Number and the Current Physical Address of the Primary Office within the State of Florida from which my (our) business is conducted is:

Name \_\_\_\_\_ Agency License Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Business Telephone Number: (\_\_\_\_) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

2. Name and license number of Applicant(s):

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ License Number \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ License Number \_\_\_\_\_

3. The tax identification number of my (our) private investigator employer which holds a Class "A" business license under chapter 493, Florida Statutes is: \_\_\_\_\_

4. Attached hereto is a true and correct legible copy of my Chapter 493, Florida Statutes, Class "A" business license, or the Class "A" business license of my (our) employer, **AND** a true and correct legible copy of my (our) Chapter 493, Florida Statutes, Class "C" individual license.

5. A duly completed State of Florida ACH Payment Authorization Form, DFS-AA-26E, found at [http://www.fldfs.com/aadir/dd\\_vendor.PDF](http://www.fldfs.com/aadir/dd_vendor.PDF), has been submitted, either by hand delivery, U.S. Mail or by common carrier, to the Direct Deposit Section, Department of Financial Services, 200 E. Gaines St., Tallahassee, FL 32399-0359; telephone number (850) 413-5517. **Attach copy of executed document.**

NOTE: Pursuant to Section 717.1400, F.S., an employer may not have a name that might lead another person to conclude that the employer is affiliated or associated with the United States, or an agency thereof, or a state or an agency or political subdivision of a state. Names that might lead another person to conclude that the employer is affiliated or associated with the United States, or an agency thereof, or a state or an agency or political subdivision of a state, include, but are not limited to, the words United States, Florida, state, bureau, division, department, or government.

(complete reverse side)

6. The Mailing Address of my (our) Private Investigative Agency Employer if different from above is:

\_\_\_\_\_  
P.O. Box or Street Address

\_\_\_\_\_  
City County State ZIP Code

7. The names of the staff, if any, who are designated to act on my (our) behalf are:

\_\_\_\_\_  
Last First Middle

\_\_\_\_\_  
Last First Middle

\_\_\_\_\_  
Last First Middle

Attached hereto is a true and correct legible copy of each person's photo-identification issued by an agency of the United States, or a state, or a political subdivision thereof.

**The staff listed above may not execute the claim form or purchase agreement on behalf of the registrant. See Sections 717.124(1) and 717.1351(6)(f), F.S.** Those listed may perform supporting office functions only, on behalf of the registrant, such as the submission of additional documentation in support of a claim and the making of inquiries about the status of a claim filed by the registrant.

Under penalties of perjury, I (we) declare that I (we) have read the foregoing document and that the facts stated in it are true, that I (we) am requesting to be registered as a Florida Unclaimed Property Claimant's Representative as part of my (our) private investigative agency's practice of private investigating, representing clients in the regular course of my (our) profession as a private investigator, and that the agents or employees designated above are employed or affiliated with my (our) agency and perform their assigned duties within my (our) agency's practice of private investigation.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

MAIL TO: Florida Department of Financial Services  
Division of Unclaimed Property  
200 East Gaines Street  
Tallahassee, Florida 32399-0358



**Department of Financial Services**  
**Division of Accounting and Auditing – Bureau of Vendor Relations**

**Vendor Direct Deposit Authorization**

<b>Section 1: Transaction Type</b>																			
<input type="checkbox"/> New request					<input type="checkbox"/> Change account number														
<b>Section 2: Authorization for Setup or Changes</b>																			
Social Security number or Federal Employer's Identification Number																			
Business Name																			
Business fax number			Business phone number																
Mailing address																			
City			State		ZIP code														
I authorize Direct Deposit Section to verify with the Financial Institution the accuracy of the account information provided. I authorize the State of Florida to initiate credit entries and, if necessary, a debit entry in order to reverse a credit entry made in error in accordance with NACHA rules. I authorize these payment instructions and accept the terms and conditions for Electronic Funds Transfer payments on the reverse side of this form.																			
Authorized Signature					Title														
Printed Name					Date														
Email Address																			
Financial Institution name					Type of Account (check one)			<input type="checkbox"/> Checking		<input type="checkbox"/> Savings									
Business Name on Account																			
Routing Number			<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>													Customer Account Number			
<input type="checkbox"/> Check this box to confirm the authorized signer has included a copy of their government issued, photographic identification. (Examples: driver's license, passport or another form of government issued, photographic identification)																			
<b>Section 3: Financial Institution</b>																			
I have verified that the account and transit-routing numbers provided above are correct. I have further verified that the person signing as the payee is an authorized signer on the account specified above.																			
Representative Name					Representative Signature														
Title of Representative					Date														
Business fax number					Business phone number														
Mailing address																			
City			State		ZIP code														
<b>Section 4: International ACH Transactions</b>																			
<input type="checkbox"/> Check this box if your funds are deposited in a U.S. financial institution and the entire amount is subsequently forwarded to a financial institution in a foreign country. See the instruction page for further information on International ACH Transactions																			
<b>For Florida Department of Financial Services Use Only</b>					<b>Send the ORIGINAL form to the address below</b>														
DM:		COMP:		FC:		Department of Financial Services Direct Deposit Section 200 East Gaines Street Tallahassee, Florida 32399-0359													
VMP:		VV:		VB:															
VVC:		APPR:																	
Comments:																			



**Department of Financial Services**  
***Division of Accounting and Auditing – Bureau of Vendor Relations***

**Instructions for Direct Deposit Authorization**

Please complete the form in its entirety. Please contact us at (850) 413-5517 or e-mail at [DirectDeposit@MyFloridaCFO.com](mailto:DirectDeposit@MyFloridaCFO.com) if you have any questions or need assistance.

**Section 1: Transaction Type:** Select the appropriate transaction type(s):

- **New request** - If a payee is not currently on direct deposit with the state.
- **Change** –If payee has a current direct deposit with the state and is requesting a change to the record. (example: change of payee name, financial institution, account number and etc)

**Section 2: Authorization for Setup or Changes:** Enter the information of the Payee.

Note: *The social security number is required to be collected pursuant to 26 USC 6109, and will only be used for the purpose of complying with filing requirements imposed by the Internal Revenue Code and to comply with Section 119.071(5)(a)7, F.S.*

The name on the Direct Deposit Payment Authorization Form must match the Payee name on file with the State of Florida Vendor payment system for payments to be sent electronically. If you are currently receiving payments via State warrant, you should list the first line of Payee exactly as it appears on the State of Florida warrant. If you are a caregiver or Guardian Ad Litem, please enter your name as the business name.

Include a copy of the authorized signer's current government issued, photographic identification. (Example: driver's license, passport or another form of government issued, photographic identification)

**Section 3: Financial Institution:** Contact your financial institution to confirm your direct deposit account information. Have the completed form signed by a Representative of the Financial Institution. The individual authorizing the form must be an authorized signer on the bank account that the funds are being sent to. Enter name of your financial institution, type of account checking or saving, the business or individual name the bank account is listed under, the routing number and account number. Verification will be conducted by the Department, via a telephone call to the Authorized Signer, to confirm the business name, account and transit-routing information of the financial institution.

**Section 4: International ACH Transactions (IAT):** Check this box if your funds are deposited in a U.S. financial institution and the entire amount is subsequently forwarded to a financial institution in a foreign country. Banking industry rules require the State, as originator of electronic payments, to identify payments where the entire payment amount is subsequently transferred to a financial institution outside the United States. The rules are referred to as "International ACH Transaction (IAT) rules" and are pursuant to requirements of the Office of Foreign Assets Control (OFAC), which is part of the United States Treasury. If an electronic payment is identified as an IAT transaction, the electronic payment must be sent to your financial institution in a special format. Contact your Financial Institution to see if IAT rules apply to you.

The State of Florida does not send payments electronically to financial institutions outside the United States.

**Terms and Conditions**

Processing time is approximately 6 to 8 weeks following receipt of the completed form. Please complete all information requested on this form. Providing account information does not authorize the State of Florida to access account activity on your account.

We will initiate a pre-notification to your financial institution prior to making payment based on this authorization. The pre-notification is a zero dollar entry transmitted to your financial institution for the purpose of verifying the accuracy of the account and transit-routing numbers provided and entered into our system.

An authorized representative of the payee must make any changes to the information provided on this form in writing. Changes to account information will cause the original authorization to be immediately inactivated and the new account information will be processed as described above. The authorization will remain in effect until terminated in writing with sufficient notice to the State to allow adequate time to effect termination. The State will not be responsible for any loss that may arise solely by reason of error, mistake or fraud regarding information provided on this Direct Deposit Payment Authorization Form.

The State cannot send payments to different accounts at this time. All payments from the State of Florida will be sent to the single account you designate.