



**ACCESS TO CAPITAL
APPLICATION FOR DEPOSIT**

The Honorable Michael W. Frerichs
Illinois State Treasurer
Attn. Time Deposit Section
400 West Monroe, Suite 305
Springfield, IL 62704
Phone: (866) 458-7327
Fax: (217) 558-3793

Dear Treasurer Frerichs:

The _____ of _____ (“Financial Institution”) hereby applies for a deposit under the Access to Capital Program (“Program”). Financial Institution acknowledges that, in order to participate in the Program, Financial Institution must have a Community Reinvestment Act (“CRA”) rating of Satisfactory or above, and an IDC Financial Publishing, Inc. (“IDC”) rating of at least 75.

Financial Institution further acknowledges that it must collateralize all deposits in accordance with the Treasurer’s Acceptable Collateral listing.

I hereby attest and certify that the following statements are true and accurate:

1. I am a _____ of Financial Institution, and I am authorized to execute this application on behalf of Financial Institution;
2. I have such familiarity with the business and affairs of Financial Institution so as to be able to knowledgeably make the statements set forth in this attestation and certification;
3. I understand that the Treasurer will rely, in part, on the statements set forth herein in connection with determining whether Financial Institution will be granted a deposit under the Program;
4. Financial Institution (a) has a CRA rating of Satisfactory or above;
5. Financial Institution has an IDC rating of at least 75;
6. Financial Institution will collateralize all deposits in accordance with the Treasurer’s Acceptable Collateral listing, available at <https://www.illinoistreasurer.gov/TWOCMS/media/doc/BankingServicesAppendixE-AcceptableCollateralList.pdf>; and
7. Financial Institution is an approved depository with the Treasurer and has completed all required documentation, including a Deposit Agreement between Financial Institution and Treasurer.

DEPOSIT REQUEST

The aggregate amount of aggregate deposit requests cannot exceed 10% of the total asset size of Financial Institution. Financial Institution will be contacted to finalize the **deposit amount, term, rate and deposit date** upon completion of the Treasurer's review and approval process and the receipt of all required documentation from Financial Institution.

1. Amount of Deposit: _____
2. Term of Deposit: ___1 month ___2 months ___3 months ___6 months ___1 year ___2 years

The term of deposit shall not be renewable. Should Financial Institution seek an additional term or additional deposits, a new application/proposal must be completed. Following the Treasurer's approval of this application, Financial Institution will receive an Addendum to the Deposit Agreement between Financial Institution and Treasurer upon completion of the ACH funding that requires execution and return to the Treasurer within ten days of the deposit date. I acknowledge that the Treasurer may withdraw this deposit at any time in the event that Financial Institution fails to comply with any of the requirements set forth herein or any of the certifications set forth herein become inaccurate or misleading.

Name of Financial Institution: _____
Authorized Representative (Printed): _____
Title: _____
Address: _____
City, County, State, Zip: _____
Telephone Number: _____
Fax Number: _____
E-mail Address: _____
F.E.I.N.: _____
How did you hear about the program? _____

Authorized Representative Signature: _____ Date: _____

SUBSCRIBED and SWORN to before me (Notary signature date should match that of the authorized representative signature date)

(Notary Public Signature) _____ This ____ day of _____, _____.

Notary Seal