STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DIRECT DEPOSIT AND DEBIT CARD AUTHORIZATION FORM

Directions: To begin, change or cancel the transmittal of workers' compensation benefit checks and/or proceeds from a settlement agreement pursuant to WCL § 32 (hereinafter settlement proceeds) directly to a Financial Institution or to a debit card. Read, complete and send this form to the insurance carrier/self-insured employer responsible for your workers' compensation claim. **Do not send to the Workers' Compensation Board.**

CLAIMANT'S RIGHTS

- This form is optional. You have the right to receive your workers' compensation benefits or settlement proceeds by paper check in the mail.
- You have the right to access all settlement proceeds at any time. If a debit card limits your daily withdrawals, you may request that settlement proceeds be paid by a paper check delivered in the mail.
- There is no limit on the amount or frequency of direct deposit or debit card withdrawals unless by express written agreement with the insurance carrier/self-insured employer responsible for your workers' compensation claim, and with the approval of the Workers' Compensation Board.
- You have the right to cancel the direct deposit or debit card at any time by checking the appropriate box on this form and forwarding the completed form to the insurance carrier or self-insured employer responsible for the workers' compensation claim.
- The insurance carrier/self-insured employer must present a debit card that is associated with a fully insured bank and the account must be in your name.
- All terms and conditions of the debit card must be disclosed to you at the time of enrollment.

AUTHORIZATIONS & UNDERSTANDINGS

- I authorize the insurance carrier and/or self-insured employer to directly deposit my workers' compensation benefits or settlement proceeds into the specified bank account or onto a debit card.
- I authorize the insurance carrier and/or self-insured employer to debit the account in order to recover any credits deposited in error. The insurance carrier and/or self-insured employer may recover credits deposited in error by any lawful means.
- I understand this consent does not authorize the insurance carrier and/or self-insured employer to recover alleged overpayments of established and awarded benefits.
- I understand that any change in my employment status may affect my right to receive benefits.
- I understand that any false statement or failure to disclose a material fact in order to obtain or increase my benefits may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.
- I understand that the failure to notify the insurance carrier and/or self-insured employer of any change in financial institution or account may delay receipt of my benefits or settlement proceeds.
- I understand that in order to change or cancel the direct deposit or debit card for my workers' compensation benefits or settlement proceeds, I need to submit this form to the insurance carrier and/or self-insured employer.

NEW YORK STATE | Workers' Compensation Board

DIRECT DEPOSIT AUTHORIZATION FORM

☐ **NEW ENROLLMENT** ☐ **CHANGE** ☐ **CANCEL**

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Claimant's Name (last, first):	**WCB Claim Number**:
Phone Number (including area code):	**E-mail Address**:
Address:	**Account Type**: ☐ Direct Deposit ☐ Debit Card
	For Direct Deposit: ☐ Checking (attach voided check) ☐ Savings Amount or Percentage to be deposited: _____

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION

I certify that I am entitled to receive the underlying compensation payments or settlement proceeds and circumstances entitling me to benefits or settlement proceeds have not changed. In signing this form, I authorize my benefits or settlement proceeds to be deposited into my account in the financial institution named, or sent to a debit card in my name.

Depositor/Claimant Certification Signature	**Date**
Joint Account Holder Certification Signature	**Date**

SECTION 2 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

Must be completed by your Financial Institution only if directing funds into a savings account or if, for deposit into a checking account, a voided personal check is **not** attached. The claimant's name MUST appear on the account.

Name of Financial Institution:	**Account Type**: ☐ Checking ☐ Savings
Depositor's Account Number (EFT Format):	**Routing Number**:

As a representative of the above named Financial Institution, I certify that this institution is ACH capable and agrees to receive and deposit the compensation payment to the account shown above. Compensation payments credited to the above account will be available to the depositor on payday.

Print or Type Representative's Name	**Phone Number** (including area code):
Signature of Representative	**Date**