STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DIRECT DEPOSIT OF BENEFIT AUTHORIZATION FORM

DIRECTIONS

To authorize transmittal of benefit checks directly to a Financial Institution, the claimant is to read the back of this form and fill in the information requested in Section 1. Then attach a voided check over Section 2 (for deposit in checking accounts only) or take this form to the Financial Institution. The Financial Institution will verify the information in Section 1 and complete Section 2. Forward the completed form to the insurance carrier/self-insured employer responsible for your workers' compensation claim. **Do not send to the Workers' Compensation Board.**

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Claimant's Name (last, first)	Workers' Compensation Case No.
Carrier Case No. (if known)	Date of Accident
Residential Address	Mailing Address (if different from residence)
Account Type: ☐ Savings ☐ Checking	☐ New/Add
Account No.:	☐ Change
Amount or %:	☐ Cancel

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION

I Certify that I have read and understand the back of this form, including the authorization for recovery and the certification pursuant to Workers' Compensation Law § 132, specifically, that by executing this form I hereby certify that I am entitled to the underlying compensation payments and that circumstances which would affect my entitlement to such benefits, as set forth on the back of this form have not changed. In signing this form I authorize my benefits to be sent to the Financial Institution named, and to be deposited to the designated account.

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: ☐ Savings ☐ Checking	
Depositor's Account Number (EFT Format)	Routing Number — — — — — — — — —	Check Digit

As a representative of the above name Financial Institution, I certify that this institution is ACH capable and agree 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 pay day.

Print or Type Representative's Name	Telephone Number
Signature of Representative	Date

DO NOT SCAN

INFORMATION - PLEASE READ CAREFULLY

The information and certification requested on this form are necessary in order for the carrier, self-insured employer and/or Special Fund to begin or to continue to accommodate your wishes for sending your benefit payments directly to your financial institution. The information supplied by the claimant will be provided only to the designated financial institution(s) and/or their agent(s) for the purpose of processing payments. Failure to provide the requested information may delay or prevent the receipt of payments.

AUTHORIZATION FOR RECOVERY

By signing this form, the claimant and each joint tenant, if any, each consent to allow the carrier and/or self-insured employer, through the financial institution, to debit the account in order to recover any benefits to which the claimant was not entitled which were deposited to the account in error or by mistake. This means of recovery shall not prevent the carrier and/or self-insured employer from utilizing any other lawful means to retrieve benefit payments to which the claimant is not entitled. However, this consent does not apply to, and the carrier, self-insured employer and/or Special Fund are specifically precluded from, attempting to recover alleged overpayments of established and awarded benefits. Such recoveries must be done in accordance with the provisions of Workers' Compensation Law §22.

ENTITLEMENT CERTIFICATION PURSUANT TO WCL §132

By executing this form the claimant, the payee, hereby certifies that he or she is entitled to the underlying compensation payments and that circumstances which would affect entitlement to such benefits have not changed. Such change in circumstances includes, but is not limited to, 1) a change in employment status such as from not working to working full or part time, from working part time to full time and from light or modified duty to regular duty AND 2) a change in medical condition as reflected in a statement by the claimant's treating medical practitioner after examination of the claimant given to the claimant. The claimant further affirmatively states that if circumstances do so change he or she will immediately notify the the Workers' Compensation Board and the carrier of such change. The claimant further acknowledges the provisions of both Workers' Compensation Law §114 and §114-a pertaining to fraudulent practices involving the procurement of workers' compensation benefits and the penalties thereunder.

INSTRUCTIONS

Claimant must complete Section 1 for NEW/ADD, CHANGE OR CANCEL account. The Account # is obtained from a personal check or from your Financial Institution. Claimant must have the Financial Institution complete Section 2, except if deposit into a checking account is desired, the claimant may attached a voided check to Section 2 instead. Forward the completed form to the insurance carrier or self-insured employer responsible for your workers' compensation claim. DO NOT SEND THIS FORM TO THE WORKERS' COMPENSATION BOARD. This form is a legal document and cannot be altered by the claimant, employer, self-insured employer or financial institution. If there are any changes, the claimant must complete a new form.

Enter the specific amount when a fixed amount is being deposited (may include cents, e.g. $100.25) or enter the specific percent when a portion of the check is being deposited (must be indicated as a full percentage, e.g. 50%).

CHANGES

Claimants may add, change or cancel a money or percent amount by completing a new Direct Deposit of Benefit Authorization Form. Financial institution changes may take up to two benefit payment periods. Claimants should maintain accounts canceled and replaced by new accounts until the new transaction is complete. If canceled accounts are not temporarily maintained until the new account received the claimant's direct deposit transaction, claimants may experience a delay in payments.

CANCELLATIONS

The agreement represented by this authorization remains in effect until canceled by the claimant or the financial institution. To cancel, the claimant must complete a new Direct Deposit of Benefit Authorization Form that contains all account data information as required in Sections 1 and 2 for the transaction to be canceled. The agreement represented by this authorization may be canceled by the financial institution by providing the claimant and the insurance carrier and/or self-insured employer with a written notice 30 days in advance of the cancellation date. The financial institution cannot cancel the authorization without notification to both the claimant and the insurance carrier and/or self-insured employer. The insurance carrier and/or self-insured employer may cancel a claimant's direct deposits with written notice at least 30 days in advance of the cancellation date.