DIRECT DEPOSIT AUTHORIZATION FORM

Do not send to the Workers' Compensation Board.

All fields required unless otherwise noted.

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

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Depositor/Claimant's Name (last, first):	
NY WCB Case Number:	**GNY Claim Number**:
Phone Number (including area code):	**Email Address**:
Address:	

Depositor/Claimant/Joint Account Holder Certification

I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed. I understand that the claim administrator may request an annual certification of continued entitlement to such payments or benefits and that such certification must be provided within sixty days in order to continue payments by direct deposit.

Depositor/Claimant Certifcation Signature:	**Date**:
Joint Account Holder Certifcation Signature (if applicable):	**Date**:

SECTION 2

Please check with your financial institution to complete the requested information in this section. Direct deposit is only available if your financial institution is part of the New York State Automated Clearinghouse. In addition, the depositor's name MUST appear on the account.

Name of Financial Institution:	**Account Type**: ☐ Checking ☐ Savings ☐ Amount or ☐ Percentage to be deposited: _____
Depositor's Account Number (EFT Format):	**Routing Number**:

Name of Second Financial Institution (if different):	**Account Type** (if multiple accounts): ☐ Checking ☐ Savings ☐ Amount or ☐ Percentage to be deposited: _____
Depositor's Account Number (EFT Format):	**Routing Number**: