STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DIRECT DEPOSIT AUTHORIZATION FORM

Directions: NYS Workers' Compensation Law allows for the direct deposit of certain workers' compensation payments into your account at certain financial institutions. 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: fill out the DD-1 form enclosed, or obtain a form from www.warrencountyny.gov/insurance and submit the form directly to the address at the bottom of the form. **Do not send to the Workers' Compensation Board**.

CLAIMANT'S RIGHTS TO DIRECT DEPOSIT

- This form is optional, but you have the right to receive your workers' compensation indemnity benefits or death benefits in the form of direct deposit. You also have the right to receive your workers' compensation indemnity benefits or death benefits by paper check in the mail.
- You have the right to cancel the direct deposit at any time by checking the appropriate box on this form and forwarding the completed form to the claim administrator responsible for the workers' compensation claim. The request will be implemented within forty-five days of receipt of notice, and thereafter payment of benefits will be sent by paper check.
- Beginning July 1, 2021, you have the right to have such payments deposited into at least two bank accounts at your request, either as a percentage of the total benefit or a fixed dollar amount for each deposit. The claim administrator may require a minimum amount of up to $20 into each bank account.

AUTHORIZATIONS & UNDERSTANDINGS

- I authorize the claim administrator to directly deposit my workers' compensation indemnity benefits or death benefits into the specified bank account(s).
- I authorize the claim administrator to debit the account in order to recover any credits deposited in error. The claim administrator may recover credits deposited in error by any lawful means. IMPORTANT: This consent does not authorize the claim administrator to recover alleged over payments 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 the insurance carrier, self-insured employer, or third-party administrator (TPA) (claim administrator) 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 for my workers' compensation indemnity benefits or death benefits, I need to submit this form to the claim administrator.
    - I understand that I have an obligation to immediately notify the claim administrator if I am no longer entitled to such payments, or of changes in circumstances which affect my entitlement to such payment.
    - I understand that the claim administrator may require me to certify annually that I continue to elect the receipt of such benefits by direct deposit, and that if I fail to do so, the claim administrator may discontinue direct deposit and thereafter provide benefits by paper check.

NEW YORK STATE | Workers' Compensation Board

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

SECTION 1 **(TO BE COMPLETED BY CLAIMANT)**

Depositor/Claimant's Name (last, first):	**WCB Claim Number**:
Phone Number (including area code):	**E-mail 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 Certification Signature	**Date**
Joint Account Holder Certification Signature	**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:	**Account Type**: ☐ Checking ☐ Savings Amount or Percentage to be deposited: _____
Depositor's Account Number (EFT Format):	**Routing Number**:

RETURN THIS FORM TO:

Warren County Self-Insurance Department
1340 State Route 9
Lake George NY 12845

If you wish to change or discontinue this election, please go to www.warrencountyny.gov/insurance to obtain a new form. For more information, call 518-761-6528 or email warrencountyinsurance@warrencountyny.gov