MURIEL GOODE-TRUFANT
Corporation Counsel

THE CITY OF NEW YORK
LAW DEPARTMENT
WORKERS' COMPENSATION DIVISION
350 JAY STREET – 9TH FLOOR
BROOKLYN, N.Y. 11201-2908

(718) 724-5500
FAX (718) 724-5496

DIRECT DEPOSIT AUTHORIZATION FORM

To begin, change, or cancel the transmittal of workers' compensation benefit checks and/or proceeds from a settlement agreement directly to your financial institution, fill out the form, and return the form and a voided check for each account directly to:

Office of the New York City Comptroller
Bureau of Accountancy (BoA)
1 Centre Street, 2nd Floor South
New York, NY 10007

Claimant's Rights to Direct Deposit

- This form is optional. 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 Office of the New York City Comptroller at the above address. The request will be implemented within forty-five days of receipt of notice, and thereafter payment of benefits will be sent by paper check.

- 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. A minimum amount of up to $20 may be necessary into each bank account.

Authorizations & Understandings

- I authorize The City of New York to directly deposit my workers' compensation indemnity benefits or death benefits into the specified bank account(s).

- I authorize The City of New York to debit the account in order to recover any credits deposited in error. The City of New York may recover credits deposited in error by any lawful means. IMPORTANT: This consent does not authorize The City of New York 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 City of New York 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 Office of the New York City Comptroller at the above address.

- I understand that I have an obligation to immediately notify The City of New York Law Department, Workers' Compensation Division 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 City of New York 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 City of New York may discontinue direct deposit and thereafter provide benefits by paper check.

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Do not Send to the Workers' Compensation Board.

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

Section 1 (TO BE COMPLETED BY CLAIMANT)

DEPOSITOR/CLAIMANT'S NAME (LAST, FIRST):	**WCB CASE NUMBER:**
SOCIAL SECURITY NUMBER:	**CNY CARRIER CASE 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 CITY OF NEW YORK 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 PRECENTAGE TO BE DEPOSITED**
DEPOSITOR'S ACCOUNT NUMBER (EFT FORMAT):	**ROUTING NUMBER**