Pennsylvania
Department of Labor & Industry
Bureau of Workers' Compensation
Att: Accounting, 100 Lackawanna Avenue, PO Box 5100
Scranton, PA 18505-5100
www.pa.gov

PAYMENT AUTHORIZATION FORM

This form is to be completed by the Person Entitled to Compensation. Check boxes that apply and follow instructions.

This form is used to request to begin direct deposit, change deposit accounts, or discontinue direct deposit/elect payment by paper check. This form must be completed and submitted to the insurance carrier/self-insured employer.

☐ Start or Change Direct Deposit:

- ☐ Checking Account: Complete Part A and B, sign the form, and submit to the insurance carrier/self-insured employer. **Include a voided check with this form to confirm the banking information provided.**
- ☐ Savings Account: Complete Part A and B, sign the form and submit to the insurance carrier/self-insured employer.

☐ Stop Direct Deposit/Elect Payment by Paper Check: Complete Part A only, sign the form and submit to the insurance carrier/self-insured employer.

Part A

First Name ____ MI ____ Last Name ____

Last 4 Digits of Social Security Number XXX - XX - ____

Telephone Number ___ - ___ - ____

Claim Number ____

Street Address ____

Secondary Street Address ____

City ____ State ____ Zip Code + 4 _____ - ____

Email Address ____ @ ____

Part B

Name of Financial Institution ____

Street Address ____

Secondary Street Address ____

City ____ State ____ Zip Code + 4 _____ - ____

Account Number ____

Transit & Routing Number ____

AUTHORIZATION STATEMENTS

- I acknowledge that failure to notify the insurance carrier/self-insured employer of any change in financial institution or account may delay receipt of compensation or settlement proceeds.
- I acknowledge that I have control over and signatory access to the above-referenced depository account.
- I acknowledge that I shall notify the insurance carrier/self-insured employer of changes in circumstances that may affect entitlement to compensation payable under the Pennsylvania Workers' Compensation Act.
- I acknowledge that any false statement or failure to disclose a material fact in order to obtain or increase compensation may result in criminal prosecution, disqualification of benefits, and repayment of money deposited into the account.
- The instructions on this form to start, stop or change direct deposit of benefits shall remain in effect for the remainder of this claim. I understand that the only way to change or stop direct deposit of benefits is to submit a new form.
- I understand that an insurance carrier/self-insured employer shall not be responsible for repaying any money deposited into an incorrect account if the sole reason for the error is incorrect information I provided.

I have read and understand the Authorization Statements on this form, and I request the action noted above.

Signature ______________________________ Date: M M / D D / YEAR

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program