Direct Deposit

CorVel is pleased to offer a secure and accelerated way for you to receive payments. Please fill out our on-line form to take advantage of Direct Deposit.

DIRECTIONS:

To begin, change or cancel the transmittal of workers' compensation benefit checks and/or proceeds directly to a financial institution: fill out the below form or utilize the link below to sign up for Direct Deposit. **Do not send a copy of this form to the NYS Workers' Compensation Board**. If you need a paper copy of the form, please print the below and follow the mailing instructions.

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). It is my responsibility to ensure the accuracy of the bank account information provided to CorVel.
- 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 CorVel your current claims 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 CorVel your current claims administrator.
- I understand that I have an obligation to immediately notify CorVel your current claim administrator if I am no longer entitled to such payments, or of changes in circumstances which affect my entitlement to such payment.
- I acknowledge that CorVel Corporation is not responsible to recover past or pending electronic payments due to inaccurate bank account information.
- I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

I understand that the CorVel my current 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 CorVel may discontinue direct deposit and thereafter provide benefits by paper check.

DIRECT DEPOSIT AUTHORIZATION FORM

Do not send to the Workers' Compensation Board.

Get started today: https://www.corvel.com/forms/eft

Don't have internet access? Please fill out the ACH Payment Authorization form below and mail to:
CorVel Corporation
ATTN: EFT Department
PO Box 22369
Portland, OR 97269-2369

Questions? Email: eft@corvel.com Phone: (503) 795-3157 Toll Free: (844) 881-2109 Fax: (866) 434-2481

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

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Depositor/Claimant's Name (last, first):	**WCB Claim Number**:
I am the claimant (Check one): **Yes:** ☐ **No:** ☐	**If not the claimant, please state name and relationship:**
Phone Number (including area code):	**E-mail Address**: (Required for Processing)
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	
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**: