Cove Risk Services LLC

DIRECT DEPOSIT AUTHORIZATION FORM

Directions: Read, complete and send this form by FAX to 800-382-8891 Attn Accounting Dept or by Mail to Claim Direct Deposit, Cove Risk Services, LLC P.O. Box 859222-9222, Braintree MA 02185. **Do not send to the Department of Industrial Accidents or your employer.**

AUTHORIZATIONS & UNDERSTANDINGS

- I authorize Cove Risk Services LLC to directly deposit my workers' compensation benefits into the specified bank account.
- I authorize Cove Risk Services LLC to debit the account in order to recover any credits deposited in error. Cove Risk Services may recover credits deposited in error by any lawful means. I understand this consent does not authorize Cove Risk Services to recover alleged overpayments of established and awarded benefits.
- I understand that I need to notify Cove Risk Services of any changes in my employment status.
- I understand that any false statement or failure to disclose return to work, resumption of earnings or receipt of Unemployment Compensation may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.
- I understand that it is my responsibility to notify Cove Risk Services, LLC in writing by completion of a new Direct Deposit Form of any change in financial institution or account.
- I understand that in order to change or cancel the direct deposit for my workers' compensation benefits or settlement proceeds, I need to submit an updated version of this form to Cove Risk Services at the FAX number or address noted above.

_____	_____
Signature	Witnessed by (signature)
_____	_____
Print Name	Print Name of Witness
_____	_____
Date	Date

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

SECTION 1 **(TO BE COMPLETED BY CLAIMANT) PLEASE PRINT or TYPE**

Claimant's Name (last, first):	**Claim Number**:
Phone Number (including area code):	**E-mail Address**:
Address: (Street no/name): (Street 2/Apartment): (City/State/Zip Code)	**For Direct Deposit**: ☐ Checking (attach voided check) _____ ☐ Savings
DEPOSITOR/CLAIMANT/ACCOUNT HOLDER CERTIFICATION I certify that I am entitled to receive the underlying compensation payments or settlement proceeds and circumstances entitling me to benefits or settlement proceeds have not changed. In signing this form, I authorize my benefits or settlement proceeds to be deposited into my account in the financial institution named.	
Depositor/Claimant Certification Signature	**Date**

SECTION 2 **(FINANCIAL INSTITUTION INFORMATION)**

Must be completed by your Financial Institution only if directing funds into a savings account or if, for deposit into a checking account, a voided personal check is **not** attached. The claimant's name MUST appear on the account.	
Name of Financial Institution:	**Account Type**: ☐ Checking ☐ Savings
Depositor's Account Number (EFT Format):	**Routing Number**:
As a representative of the above-named Financial Institution, I certify that this institution is ACH capable and agrees to receive and deposit the compensation payment to the account shown above. Compensation payments credited to the above account will be available to the depositor on payday.	
Print or Type Representative's Name	**Phone Number** (including area code):
Signature of Representative	**Date**