Workers' Compensation
Direct Deposit Authorization

Please check the appropriate box.

☐ **WORKERS' COMPENSATION** (PERMANENT DISABILITY)	☐ **COAL WORKERS' PNEUMOCONIOSIS** (FEDERAL BLACK LUNG ONLY)

Name:

Social Security Number: ☐ ☐ ☐ - ☐ ☐ - ☐ ☐ ☐ ☐

Pursuant to Section 7 of the Privacy Act of 1974, the disclosure of your Social Security Number is mandatory. Social Security Numbers are necessary to properly maintain records concerning your direct deposit payments as is required and authorized by the federal government for tax administration purposes. See generally, 42 U.S.C. § 405(c). Failure to provide a Social Security Number will prevent us from processing your direct deposit request.

Telephone Number: ☐ ☐ ☐ - ☐ ☐ ☐ - ☐ ☐ ☐ ☐

Address 1:

Address 2:

City: **State:** **Zip Code:**

ACCOUNT INFORMATION

Bank Name:

Please select one: ☐ **Add** ☐ **Change** ☐ **Cancel** **Please select one:** ☐ **Checking** ☐ **Saving**

Please attach a voided check with this form.

I hereby authorize the State of West Virginia, hereinafter called State, to initiate credit entries as indicated on the form above. I further authorize the State to initiate debit entries as adjustments for credit entries made in error. This authority is to remain in effect until the State receives written notification from me of termination in such time and manner as to afford reasonable opportunity for action.

Signature _____ **Date**

Claimant Name: **Claim Number:**

For information regarding your direct deposit, contact the ePayments Division at 800-500-4079.

Please return to:
Claims Services
PO Box 50541
Charleston, WV 25305