PMA COMPANIES

Instructions

To begin, change or cancel the transmittal of workers' compensation benefit checks directly to a financial institution, print, complete, and send this form to: PMA Companies, PO Box 5231, Janesville, WI 53547-5231 or Fax to 1-800-432-9762. **Do not send to the NY Workers' Compensation Board.** PMA Companies ("PMA") includes Pennsylvania Manufacturers' Association Insurance Company, Manufacturers Alliance Insurance Company, Pennsylvania Manufacturers Indemnity Company, PMA Management Corp., and PMA Management Corp. of New England, Inc. You may download the form from our website at: https://www.pmacompanies.com/support/injured-workers or contact our customer service center at 1-888-476-2669 to request a form be mailed to you.

Your Rights

- This form is optional. You 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 or change the distribution at any time by checking the appropriate box on this form and forwarding the completed form to PMA at the address or fax number above. It may take up to 45 days to process your request.
- Please note that benefits paid by your employer are not subject to this enrollment process.

Authorizations and Understandings

- You may choose to have your benefits deposited into either one or two bank accounts. If you choose two accounts, you must identify your primary account and your secondary account.
- The distribution between the two accounts must be designated as either a fixed dollar amount to each account, or a percentage of the total benefit to each account.
- If you choose the fixed benefit amount option and your benefit amount changes, we will deposit your benefits to your primary account first, and any remaining balance to your secondary account.
- I understand that direct deposit will be terminated where I have not received a benefit payment for 6 months and that I will need to complete a new form to begin receiving benefits by direct deposit again.
- I authorize PMA to directly deposit my workers' compensation or death benefits into the specified bank account(s).
- I authorize PMA to debit the account in order to recover any credits deposited in error, by any lawful means.
- I understand that the consent does not authorize PMA to recover alleged overpayments 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 PMA of any change in financial institution or account may delay receipt of my benefits.
- I understand that I have an obligation to immediately notify PMA if I am no longer entitled to such payment, or of changes in circumstances which may affect my entitlement to such payment.

NEW YORK DIRECT DEPOSIT AUTHORIZATION FORM

Claimant Name: _____
Claimant Address: _____
_____
Claimant Phone: _____
Claim Number: _____

☐ New Enrollment ☐ Change ☐ Cancel

Banking Information

Primary Account

Bank Name: _____
Routing Number: _____
Bank Account Number: _____
% _____* (1-100) **OR** $_____*

**Note: Any remaining balance will be deposited into your Secondary Account if elected*

**If electing a fixed dollar amount, and your entitlement to benefits is less than the elected amount, then your benefits will be deposited into your Primary Account.*

Bank Account Type (check one): ☐ Checking ☐ Savings

Secondary Account (if elected)

Bank Name: _____
Routing Number: _____
Bank Account Number: _____
Bank Account Type (check one): ☐ Checking ☐ Savings

Please select desired method of delivery for payment remittance information:

☐ Email Email Address: _____

☐ Standard mail Remittance will be mailed to your home address on record.

Depositor/Claimant/Joint 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(s) in the financial institution(s) named. I understand that my name must appear on the account(s).

I also acknowledge my rights, authorizations and understandings as explained in this "Direct Deposit Authorization Form."

Claimant Name/Please Print: _____

Claimant Signature _____ Date _____