CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF HUMAN RESOURCES
WORKERS' COMPENSATION DIVISION

OFFICIAL USE ONLY

Claimant Payment Preference Form

Employee Name: Last, First M.I.

Employee ID

Payment Preference Authorization

I hereby authorize the Workers' Compensation Division to change my payment preference as specified below. Upon receiving a completed Claimant Payment Preference Form, it may take up to 30 days to update the payment preference. I understand that this authorization will remain in full force and effect until I complete and submit a new Claimant Payment Preference Form, and will apply to all open claims.

I also understand that I must notify Payroll at my department for any changes to my direct deposit account, including closing an existing account or changes to my preferred direct deposit account. Failure to do so may result in delays to receiving workers' compensation benefits.

PAYMENT PREFERENCE:

I would like to receive my future Workers' Compensation benefits via:

- ☐ **Direct Deposit (ACH)[1]**
- ☐ **Mailed Paper Check**

[1]If an overpayment is made or a payment is deposited in your bank account in error, the Workers' Compensation Division reserves the right to initiate a reversing entry to correct the erroneous transaction.

Employee's Signature (Please sign with a blue or black pen)_____ Date _____

Work Phone #_____ Home Phone #_____

Email Address_____

Completed forms may be directed to the attention of your assigned claims examiner, by mail or fax, or you may scan and send the form electronically by e-mail.

Workers' Compensation Division USE ONLY: Claims Assistant Name and Date_____