Direct Deposit Authorization Form

Application Type

NEW ☐ **UPDATE** ☐

Benefit Recipient Personal Information

NAME OF CLAIMANT (**As per Social Security Registration Card**)	
SOCIAL SECURITY NUMBER (**As per Social Security Registration Card**)	
ADDRESS	
TELEPHONE NUMBER	
EMAIL ADDRESS	

Benefit Recipient Bank or Credit Union Account Information

NAME OF ACCOUNT HOLDER(S) (**As it appears on the account records**)	
NAME OF FINANCIAL INSTITUTION **(in full)**	
BRANCH NAME **(where account was first opened)**	
ACCOUNT NUMBER	
TRANSIT NUMBER **(if any)**	
ACCOUNT TYPE **(if any)**	

By signing this form, I hereby declare that the banking or credit union information provided herein is accurate and I authorize my benefit payment(s) to be sent to and deposited to the financial institution and account named above. I also declare that I will submit a new form to Social Security Board if there are changes to the account information or contact details.

SIGNATURE OF CLAIMANT: _____DATE: _____

Kindly attach one of the following:

- A copy of the bank or credit union account card or book; **OR**
- A bank slip or letter certified by the bank or credit union or by the insured person's employer; **OR**
- A printed version of the online banking information.

NOTE: The document presented must show the account holder's name, name of financial institution, branch name (location) and full account number inclusive of transit number and account type where applicable.

DISCLAIMER: The Social Security Board will not be liable for any charges resulting from direct deposit errors associated with the account information provided above. You may be required to pay all associated charges prior to the benefit payment being reprocessed.

Official Use Only:

DATE RECEIVED _____ BRANCH: _____

DATA ENTRY OFFICER: _____
Name in Print Signature Date

VERIFICATION OFFICER: _____
Name in Print Signature Date