

Worker Name	Claim Number
-------------	--------------

<input type="checkbox"/> New direct deposit	<input type="checkbox"/> Changed direct deposit	<input type="checkbox"/> End direct deposit
---	---	---

**Authorization (Must be completed)**

**I hereby authorize the Workers Compensation Board of Manitoba (WCB) to deposit my payments directly into the below noted account.**  
 This authorization is in force until I provide WCB with notice to stop the direct deposit.

Worker signature	Date DD/MM/YYYY	Phone Number
------------------	--------------------	--------------

Banking information will be used for all future payments and claims until the WCB is advised otherwise. Contact the WCB immediately if your bank account changes.

**Direct Deposit Information | Complete one of the following options**

**Option 1:**

Attach a personalized cheque with your name (address is optional)

- Must be preprinted by the financial institution
- Print VOID across the front of your cheque

Or attach a photo of your banking information from your financial institution.

- The photo must include your full name, transit number, branch number and account number.

Submit your completed form



**OR Option 2:**

• To be completed by your financial institution and **MUST** be stamped when a void pre-printed cheque is not provided or if deposit is to be directed to your Savings Account:

Branch number 5 characters	Bank ID 3 characters	Account Number can be up to 12 characters
-------------------------------	-------------------------	--

	0	
--	---	--

Financial Institution (F/I) Stamp Include Financial Institution name and address	Name(s) of account holders:
---	-----------------------------

F/I Representative	Date DD/MM/YYYY	Phone Number
--------------------	--------------------	--------------

**Submit this form to [DirectDeposit@wcb.mb.ca](mailto:DirectDeposit@wcb.mb.ca)**