AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER

Re: Injured Employee or Beneficiary:
Claim Number:
DWC Number:
Date of Injury:
Employer:

1.) Please select the appropriate action you wish Texas Mutual Insurance Company to take:

( ) Begin sending my income benefit payments by Electronic Funds Transfer (EFT).
( ) Stop sending my income benefit payments via Electronic Funds Transfer.
( ) Please review and make the account changes listed below.

2.) Please provide your account information:

Name of Financial Institution: _____

Address of Financial Institution: _____

City: _____ State: _____ Zip: _____

Electronic Routing Transit Number /ABA Number:

_____

***Please contact your financial institution to verify your *electronic* routing transit number and account number prior to submitting this request. The correct routing and account numbers may differ from the number printed on your checks and deposit slips.**

Account Number: _____

Type of Account: ( ) Checking ( ) Savings

3.) Please attach one of the following:

(1) a check with your account information with the word "void" handwritten across the face of the check ; or
(2) a deposit slip with your account information with the word " void" handwritten across the deposit slip.

4.) Please read and sign below:

I understand that the Texas Mutual Insurance Company will review my written request for EFT payments to determine if the duration of income benefits is sufficient to meet the requirements as outlined in rule 124.5. I understand that the electronic transfer of benefits will begin starting with the first benefit payment due on or after the 21st day after the requirements of subsection 124.5(g) are met. I authorize Texas Mutual Insurance Company to initiate credit entries to my account with the financial institution named above. This authorization will remain into effect until the earlier of :

(1) The first working day after Texas Mutual Insurance Company receives a written request to terminate EFT, or
(2) The point in which no further income benefits are due.

Print Name _____

Sign Name_____

Date_____

5.) Send completed request to:

Texas Mutual Insurance Company
PO Box 12029
Austin, TX 78711
Attention: [ADJNAME]

With a few exceptions, an individual may upon request be informed about the information that the Texas Mutual Insurance Company collects about them, receive and review that information, and correct incorrect information. To learn more about the information that the Texas Mutual Insurance Company may collect, please call (800) 859-5995 and select the option to speak with an information specialist.