CHUBB

Do not send to the Workers' Compensation Board. Please complete and return the document to:
P.O. Box 4700 WCNY, Chesapeake, VA 23327 or via email at chubbenroll@chubb.com

[ ] New Enrollment [ ] Change [ ] Cancel

Section 1 (To Be Completed By Claimant)

Depositor/Claimant' Name (last, first):	**CHUBB Claim Number:**
	WCB Claim Number:
Phone Number (Including area code):	**Email Address:**
Address:	
DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed. I understand that CHUBB may request an annual certification of continued entitlement to such payments or benefits and that such certification must be provided within sixty days in order to continue payments by direct deposit.	
Depositor/Claimant Certification Signature	**Date**
Joint Account Holder Certification Signature (if applicable)	**Date**

Section 2

Please check with your financial institution to complete the requested information in this section. Direct deposit is only available if your financial institution is part of the New York State Automated Clearinghouse. In addition, the depositor's name MUST appear on the account.

Name of Financial Institution:	Account Type: **[ ] Checking [ ] Savings** **Amount or Percentage to be deposited:** **[INSERT $ OR %]**
Depositor's Account Number (EFT Format):	Routing Number (9 digits):

Name of Second Financial Institution:	Account Type: **[ ] Checking [ ] Savings** **Amount or Percentage to be deposited:** **[INSERT $ OR %]**
Depositor's Account Number (EFT Format):	Routing Number (9 digits):