

Memo Regarding the Direct Payment Plan



Generally, when you elect to continue the health insurance, life insurance, dental plan, vision plan, and/or the medical expense reimbursement account, your method of payment is through the Direct Payment Plan. If two or more benefits are continued, the premiums for each benefit are combined into one deduction amount.

To authorize regularly scheduled payments to be made from your bank account, you must complete the Direct Payment Plan form located on the reverse side of this memo. Be sure to attach a voided check. Your deduction will be taken from your account on the 15th of the month. Please note that coverage is paid in advance. For example, a deduction on January 15th from your bank account pays for February coverage. Proof of payment will appear on your bank statement.

A personal check may be required to bring your coverage up to date. Failure to submit requested payment and/or paperwork in a timely manner may result in loss of coverage.

RETIREES:

Retirees who are able to have **health insurance** premiums withheld from their South Dakota Retirement System Benefit may do so. However, if a retiree continues the life plan, dental plan, vision plan, and/or the medical expense reimbursement account, the Direct Payment Plan must be used for these products.

COBRA PARTICIPANTS:

When the health insurance, life insurance, dental plan, vision plan, and/or the medical reimbursement account benefits are continued through COBRA, the initial payment by personal check will be requested. Then, subsequent payments will be made through the Direct Payment Plan.

Authorizations will remain in effect until you submit written notification to the Bureau of Human Resources to terminate the authorization; until the designated period of participation has expired; or until coverage is terminated due to nonpayment of premium.

If the Bureau of Human Resources initiates a change that affecting the amount of your payment, we will notify you at least 30 days before the payment date. When our office receives a written request initiated by you affecting the amount of your payment, the change will be made on our next scheduled deduction date or the upcoming payment deduction date requested.

If you have any questions regarding this process, please contact our office at 773-3148.

DIRECT PAYMENT PLAN SD EMPLOYEE BENEFITS PROGRAM



Completion of this form authorizes a monthly payment to be deducted from your checking or savings account. Your payment will automatically be made on the 15th of the month with proof of payment appearing on your bank statement. In the event the 15th falls on a holiday or weekend, the deduction will be made on the first banking day following the deduction date. Enrollment in the Medical Expense Reimbursement Account, Health, Life, Dental, and/or Vision Plans will be combined into one line item payment from your account.

AUTHORIZATION FOR DIRECT PAYMENT

I authorize the SD Employee Benefits Program and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify the SD Employee Benefits Program in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. Otherwise, this authority will remain in effect until the designated period of participation has expired.

I have attached a voided check from the bank/credit union from which payment will be made. If payment is not made from my account due to non-sufficient funds, my signature authorizes the Benefits Program to make a second attempt at deducting payment within 4 to 6 days of the original deduction date. Associated costs incurred by non-sufficient funds will be my responsibility. If payment is not deducted after the second attempt, coverage will be canceled.

(Name of Financial Institution – Please Print)

(City)

(State)

(Zip Code)

(Account holder Name – Please Print)

(Daytime Phone #)

(Account holder Address)

(City)

(State)

(Zip Code)

Participant Name (if not account holder): _____

Participant SSN or Alternative ID# _____

Routing No. _____ Account No. _____ Checking ___ or Savings ___

(Circle All That Apply) Deduct premium for: Health Life Dental Vision Medical Reimbursement Account

(Account Holder Signature)

(Date)