

Direct Payment Plan Form  
PMB 0141-1 Bureau of  
Human Resources  
500 East Capitol Ave  
Pierre, SD 57501  
Fax: 605.773.6840  
Phone: 605.773.3148 or 877.573.7347

## Memo Regarding the Direct Payment Plan

SOUTH DAKOTA  
state employee  
benefits program  
learn. act. thrive.

Generally, if you elect to continue the health insurance, dental insurance, vision insurance, and/or the medical expense spending account the method of payment will be through the Direct Payment Plan.

Retirees are the exception because they are able to have health insurance premiums withheld from their South Dakota Retirement System benefit. If a Retiree continues dental insurance, vision insurance, and/or the medical expense spending account the Direct Payment Plan must be used.

A personal check may be required for the initial premium amount to bring coverage up to date. If you receive an initial bill from the Bureau of Human Resources, Benefits Program, the first payment for continuation coverage is due no later than 45 days after the date of the election. Future payments are then deducted through the Direct Payment Plan. If the first payment is not received, in full, within 45 days after election, all continuation coverage rights under the plan are forfeited.

**To authorize regularly scheduled payments from a bank account, the Direct Payment Plan Form on the reverse side of this memo must be completed. Be sure to attach a voided check.**

Deductions will be taken from the account on the 16<sup>th</sup> of each month. In the event the 16<sup>th</sup> of the month falls on a weekend or holiday, the deduction will be made on the first banking day following the 16<sup>th</sup>.

Please note that coverage is paid in advance. For example, a deduction on January 16, from a bank account, pays for February coverage. Proof of payment will appear on the bank statement. If two or more benefits are continued, the premiums for each benefit are combined into one deduction amount.

Authorization will remain in effect until:

- You submit written notification to the Bureau of Human Resources to terminate the authorization,
- The designated period of participation has expired, or
- Coverage is terminated due to nonpayment of premium.

If the Bureau of Human Resources initiates a change 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 the member, affecting the amount of 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 1.877.573.7347, option 2.

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## DIRECT PAYMENT PLAN



Completion of this form authorizes a monthly payment to be made from a checking or savings account. Deductions will automatically be taken from the account on the 16<sup>th</sup> of the month. In the event the 16<sup>th</sup> of the month falls on a weekend or holiday, the deduction will be made on the first banking day following the 16<sup>th</sup>. Proof of payment will appear on the bank statement. If two or more benefits are continued, the premiums for each benefit are combined into one deduction amount.

### AUTHORIZATION FOR DIRECT PAYMENT

I authorize the Bureau of Human Resources, Benefits Program and the financial institution named below to initiate entries to the authorized checking/savings account. Authorization will remain in effect until I submit written notification to the Bureau of Human Resources to cancel it in such time as to afford the Bureau of Human Resources and the financial institution a reasonable opportunity to act on it. Otherwise, authorization 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 Bureau of Human Resources, 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 Insurance ID# \_\_\_\_\_

Routing No. \_\_\_\_\_ Account No. \_\_\_\_\_ Checking \_\_\_ or Savings \_\_\_

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

(Account Holder Signature)

(Date)

(Participant Signature- if different from account holder)

(Date)