



FLEXIBLE BENEFIT PLAN
STATE OF SOUTH DAKOTA

Direct Deposit Authorization of Reimbursement Claims

For Employee/Participant

Employee Insurance ID: _____

Employee/Participant Name: _____ Employee SSN: _____

I hereby authorize DAKOTACARE to initiate credit entries to my:

[] Checking account or [] Savings account

indicated below and the depository named below (Depository) to credit the same to such account.

** Please note that before the ACH option takes effect a pre-notification transaction needs to be sent to the bank for approval therefore the next disbursement after this election will still come in the form of a check. Then the remaining payments will be via ACH. Any ACH transaction stopped by the bank will cancel your ACH election until corrections can be made.

An actual voided check must be attached
Tape voided check here
This form will not be processed without a voided check

Account Number: _____

Depository (Financial Institution): _____ Branch: _____

City: _____ State: _____

Bank ACH Transit Routing Number: _____

This authority will remain in full force and effect until DAKOTACARE has received written notification from me of its termination in such time and in such manner as to afford DAKOTACARE a reasonable opportunity to act on it. DAKOTACARE is not responsible for any bank fees related to expenditures made before an actual ACH deposit is in your account. It is your responsibility to verify that the funds are in your account before you expend them.

Signature: _____ Date: _____

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