Client Automatic Withdrawal from Checking Information

Please fill out the following to setup an automatic withdrawal of your monthly premium payment due to DAKOTACARE and return the form along with a **voided** check to:

DAKOTACARE
Attn: Accounting
P.O. Box 7406
Sioux Falls, SD 57117-7406

Requested Automatic Transfer Start Date: _____ 1st, 20____

Client ID: _____

Client Name: _____

Bank Name: _____

Bank Address: _____

_____

Bank Phone#: _____

Bank ABA#: _____
9-Digit #

Account Name: _____

Account Number: _____

Account Type: ☐ Checking or ☐ Savings

I authorize DAKOTACARE to initiate electronic debit entries to my checking or savings account indicated above. This authority shall 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.

Signature: _____

Date: _____

Please refer to your monthly billing statements for future transfer amounts.

The amount transferred each month will be the Total Due on your monthly statement minus any payments made after billing cutoff.

If you have any questions please feel free to contact the Accounting Department **at (605) 334-4000.**