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
2600 West 49th Street
Sioux Falls, SD 57105

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.**