DAKOTACARE FLEX

Direct Deposit Authorization of Reimbursement Claims

For Employee/Participant

Employee Insurance ID: _____ (found on insurance card)
OR
Employee/Participant Name: _____ **Employee SSN:** _____

I hereby authorize DAKOTACARE to initiate direct deposit of Flex reimbursements to my:

☐ Checking account or ☐ Savings account

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

Financial Institution: _____ **Branch:** _____

City: _____ **State:** _____

Telephone Number: _____

Bank ACH Transit Routing Number: |: _ _ _ _ _ _ _ _ _ :|

Account Number: _____

OPTIONAL: PLEASE ATTACH A VOIDED CHECK TO ENSURE ACCURATE ACCOUNT INFORMATION.

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.

** Any ACH transaction stopped by the bank will cancel your ACH election until corrections can be made.

Signature: _____ **Date:** _____

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