PO Box 91110
Sioux Falls, SD 57109-1110
(605) 328-6868
(877) 305-5463

PRE-ARRANGED PAYMENT AUTHORIZATION

Plan Type: ☐ elite1 ☐ Medicare Supplement/SELECT
Applicant Type: ☐ New Applicant ☐ Existing Plan Member

IMPORTANT: Please complete and sign this form in order to have your monthly premiums automatically deducted from your checking account. Mail this form along with a **voided check** at the above address. Please keep a copy for your records.
It takes approximately two weeks to establish monthly automatic account withdrawal. If your next premium is due during the two-week processing period, automatic deduction will NOT be in force and **2 months premiums will be deducted the following month**. Deductions are taken on or around the 10th of each month. A record of each automatic withdrawal will appear on your regular bank statement.

Policy Holder Name	Social Security Number	Health Plan ID Card Number (if you are a current Member)

I hereby authorize Sanford Health Plan to initiate debit entries to my checking account indicated below, and the bank named below, to debit the same to such account. **I have included a voided check from the account I want debited.**

Bank Name	Branch	Depository (Routing) Number	Account Number

Bank Address

City	State	Zip Code

On (today's date) ____/____/____ I authorize Sanford Health Plan, mailing address PO Box 91110, Sioux Falls, SD 57109-1110, to initiate electronic entries to my checking/savings account and agree to the terms listed on this authorization form for payment of ___________________________________(indicate insurance plan name/type).

To cancel your automatic account withdrawals please notify us in writing at the above address at least 20 days prior to your next scheduled withdrawal.

This authorization is to remain effective until the Sanford Health Plan and the Bank have received **written notification** from me of its termination in such time and in such a manner as to afford Sanford Health Plan and the Bank a reasonable opportunity to act on it. I authorize Sanford Health Plan to change the amount of the debit provided **written notice** of such change is given in such a time as to afford me a reasonable opportunity to act on it.

Account Holder Signature	Date

 White Copy: Health Plan *Pink Copy: Applicant*