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

SANFORD HEALTH PLAN

Payment Authorization (ACH) Change

for non-Marketplace members

Plan Type: ☐ *Simplicity* Individual ☐ Sanford TRUE ☐ elite1 ☐ Medicare Supplement/Select

Forms received by the first of the month of the effective date, will automatically deduct from your bank account on the 10th of the month or next business day.

IMPORTANT: By completing this form you have elected to have your monthly premiums automatically deducted from your checking or savings account. A record of each automatic withdrawal will appear on your bank statement.

I authorize Sanford Health Plan to initiate electronic debit entries to the bank account indicated below. This authority is to remain in full force until I terminate this authorization in writing. I understand that if I want to cancel my automatic account withdrawal, I have to notify Sanford Health Plan in writing at least 20 days prior to the next scheduled withdrawal.

Policy Holder Name: _____ SS#: _____

Member ID # *(if you are a current member)*: _____

Bank name: _____ Bank Phone: _____

Bank address: _____

Transit routing #: _____ Account #: _____ ☐ Checking ☐ Savings

Signature: _____ Date: _____

NOTE: Include a voided check for checking accounts or a deposit slip for savings accounts with this authorization form. This will be used to verify transit routing number and account number information. Mail this form along with a voided check or deposit slip in the enclosed envelope. Please keep a copy for your records.

Mail to: Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

Or fax to: (605) 328-7197