



South Dakota Farm Bureau Health Plans

PO Box 1424

Columbia, TN 38402-1424

Phone: 833-480-2188

Billing Fax: 931-560-4278

billingforms@fbhp.com

Bank Draft Authorization Form

General Information

- All requested information below is required to authorize your automatic bank draft.
- Upon completion, please submit to address, fax or email above.
- For bank changes, the form must be received at SDFBHP by the 20th of the month to be effective the first of the following month.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- Cancellation- the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to South Dakota Farm Bureau Health Plans. Coverage will remain in effect until the paid-to-date. See your contract for specific information

Applicant/Subscriber Information

First Name	MI	Last Name
Requested Date of Change (for existing Subscriber)	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

Banking Information

Authorization Type	
New Applicant <input type="checkbox"/>	Existing Subscriber <input type="checkbox"/>
Please complete or attach voided check.	
Account Type: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	
Name of Financial Institution	
Address of Financial Institution	
Routing Number	Account Number

Authorization

I hereby authorize South Dakota Farm Bureau Health Plans to initiate debit entries from the account indicated above for the monthly payment of health and/or dental coverage. The depository named above is authorized to debit my account. I acknowledge I am authorized to sign this agreement on behalf of all covered individuals and signatories to the account. I understand I have the right to revoke this authorization by notifying South Dakota Farm Bureau Health Plans in writing at least ten (10) days prior to the time payment is due. I further agree that should a debit be dishonored, whether with or without a cause and whether intentionally or inadvertently, South Dakota Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Applicant/Subscriber Printed Name (Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)	Payor Printed Name
Applicant/Subscriber Signature	Today's Date
Payor Signature	Today's Date

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.