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 ☐ Existing Subscriber

Please complete or attach voided check. Account Type: ☐ Checking Account ☐ Savings Account

☐ Check this box if the Primary Name on Bank Account is not the same as the Primary Applicant for coverage. This serves as authorization for payments to be made from the bank account entered below.

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.