Direct Deposit Authorization Form

Bureau of Human Resources
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Pierre, South Dakota 57501-5070
Phone: 605.773.3148
Fax: 855.806.4497

State of South Dakota
Workers' Compensation Program

Completion of this form authorizes your disability benefit payment to be deposited directly into a checking or savings account via Automated Clearing House (ACH) transactions. All disability benefits to which you are entitled will be deposited via ACH into the account you authorize below. Proof of such deposit will appear on your bank statement.

Employee/Participant Name: _____ **SSN:** _____ / _____ /_____
Last First MI

I hereby authorize the State of South Dakota Workers' Compensation Program (Program), and Risk Administration Services, Inc. (RAS) as its program administrator, to initiate credit entries into the depository which I have indicated below, and to initiate any debit or credit entries to my account that may be needed to correct any errors that may have occurred.

☐ Checking Account ☐ Savings Account

NOTE: Before the ACH option takes effect, a pre-notification transaction may be sent to the bank for verification of bank and account information. The next disbursement after any such election will continue to be a negotiable check. The succeeding and remaining payments to you will be via ACH. Any ACH transaction stopped by the bank will cancel your ACH election until corrections can be made.

****A VOIDED CHECK MUST BE ATTACHED****

TAPE VOIDED CHECK HERE

THIS FORM WILL NOT BE PROCESSED WITHOUT A VOIDED CHECK

Account Number: _____

Depository (Financial Institution): _____

Address of Depository: _____
Street City State Zip

Bank ACH Transit Routing Number: _____

I give authorization to the financial institution above to release my address and telephone number to a duly authorized representative from the Program and from RAS.

I agree to advise the Program and RAS of any changes in my address and telephone number. In the event the Program and RAS are not advised of a change in my address and telephone number, payment of disability benefit payments may be delayed.

This authorization and resulting authority will remain in full force and effect until the Program and RAS have received written notification from me of its termination in such time and in such manner as to afford the Program and RAS a reasonable opportunity to act on it or until a determination is made by the Program and RAS that I am no longer eligible to receive disability benefit payments.

Neither the Program nor RAS is responsible for any bank fees related to expenditures made before an actual ACH deposit is credited to your account. It is your responsibility to verify that the funds are credited to your account before you expend them. Further, you acknowledge and agree that all ACH transactions you authorize herein and the use of such funds shall comply with all applicable laws.

Signature: _____ **Date:** _____