Direct Deposit
Payment Request Form

Ministry of Health
Drug Plan & Extended Benefits Branch

2nd Fl 3475 Albert St
REGINA SK S4S6X6

Check one only

☐ To Start Direct Deposit ☐ To Change Information on Direct Deposit

Full Name _____

Mailing Address _____ Postal Code _____

Email Address _____

By providing your email address, your payment advice will be delivered to the above email address.

1. Sign this form authorizing payment by direct deposit to your account.

I hereby authorize direct deposit to the account designated below. I understand that the information provided herein will be used by the Government of Saskatchewan for the purposes of payment processing and accordingly is available to all ministries of the Government of Saskatchewan for such purposes. Further, I understand that this agreement may be cancelled at any time by myself or the Government of Saskatchewan by written notice.

Signer's Name _____ Title _____

(please print) (please print)

Authorizing Signature _____ Telephone Number _____

2. Please do A or B: (A is preferable, unless we are paying to a non-chequing account)

A) Attach a current blank company cheque or photocopy marked "Void". The payee's name and address should be pre-printed on the cheque.

B) Have **an official from your financial institution** provide the following information regarding your current account.

Branch	Institution	Account Number

_____

Name and Address of Financial Institution

_____

Financial Institution Official's Signature and Stamp

Please scan signed document and submit to drugplan.invoices@health.gov.sk.ca or by fax at (306) 787-8679

For Office Use Only

Supplier Site Name _____

Date Received in Finance _____ Received by _____

Date Entered on MIDAS _____ Entered by _____