BlueChoice HealthPlan
South Carolina

NCQA Accreditation EXCELLENT

State Continuation Premium Assistance

Employer Information

Group Name: ______________________________ Group Number: ________________________

Employee Information

Employee's Name: ___________________________ Employee's SSN: _______________________

Effective Date of Coverage: ____________________ Date of Involuntary Termination: ______________

Employer hereby attests that the above Employee was involuntarily terminated. If Employer becomes aware that Employee is eligible for other group health insurance or Medicare, Employer will immediately notify BlueChoice HealthPlan at 886-280-0766.

____ ________________
Authorized Representative of Employer Date

It is imperative that this form be returned via fax within two business days of receipt or we will not be able to process the state continuation subsidy on behalf of this employee.

Please fax this form to: 803-735-9675

We have received an application of termination and/or State Continuation election from you. For us to continue to process this application we need help from you. As you may be aware, under the American Recovery and Reinvestment Act of 2009, former employees and their dependents may be eligible for premium assistance for state continuation coverage if certain requirements are met. BlueChoice HealthPlan of South Carolina is providing the following attestation to help you in complying with the Act.

The subsidy began March 1, 2009. All prior eligibility and coverage requirements for state continuation still apply. Please fill out one attestation for each terminated employee.

Please remember that this employee is still part of your employer group health plan and is subject to all provisions of your employer group contract. In order to appropriately administer the Act's requirements, BlueChoice HealthPlan will bill the employee directly for his or her portion of the premium.

If you need any additional information, please contact a customer service representative at 1-866-280-0766.