

## Group Attestation Form

We recently told you about an attestation form we are requiring all groups to complete. The purpose of this form is to verify a group's current contribution level and contribution level on March 23, 2010.

Certain reductions to a group's contribution level could cause the group to lose grandfathered status. Groups are required to return the completed form 30 days prior to renewal. Failure to do so will cause:

- Loss of grandfathered status
- Addition of mandated preventive benefits and possible rate increase
- Implementation of new appeals process
- Changes to reimbursement for emergency services in an out-of-network hospital's emergency room

You can help your groups by reminding them to complete the form and fax it to us at 803-264-0143. We may contact you for assistance if a group does not return the form in a timely manner.

We will continue to check contribution levels on an annual basis.

We've attached a copy of the form.



South Carolina

Blue Cross BlueShield of South Carolina  
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Blue Cross and Blue Shield Association

**Attestation Regarding Employer Contribution**

I, \_\_\_\_\_ (Name), as authorized representative of \_\_\_\_\_ (Group Name), hereinafter “the Plan,” do hereby attest that the Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act, hereinafter, “PPACA.”

I understand that failure to execute and return this attestation form to BlueCross BlueShield of South Carolina, hereinafter “BlueCross,” 30 days prior to the Plan renewal date will result in the loss of grandfathered status for the Plan and that BlueCross will add additional health care reform requirements pursuant to PPACA which may cause an increase in premium.

I understand and agree that the Plan will immediately notify BlueCross of any change in the Employer’s contribution amount. I also understand and agree that the Plan will indemnify BlueCross for any liability resulting from the Plan’s ineligibility for or loss of grandfathered status.

<u>March 23, 2010</u>			<u>Renewal</u>		
	Premium Rate	Employer Contribution (%)		Premium Rate	Employer Contribution (%)
Plan _____			Plan _____		
Single	_____	_____	Single	_____	_____
Family	_____	_____	Family	_____	_____
Emp/Ch	_____	_____	Emp/Ch	_____	_____
Emp/Sp	_____	_____	Emp/Sp	_____	_____
Plan _____			Plan _____		
Single	_____	_____	Single	_____	_____
Family	_____	_____	Family	_____	_____
Emp/Ch	_____	_____	Emp/Ch	_____	_____
Emp/Sp	_____	_____	Emp/Sp	_____	_____

I have read and understand this attestation and certify that the information provided herein is accurate, complete and current to the best of my knowledge and belief as of the signature date.

Signed: \_\_\_\_\_  
 \_\_\_\_\_  
 (Print name of signature)

Group #: \_\_\_\_\_  
 Group Telephone#: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

E-mail: \_\_\_\_\_

***Please fax to 803-264-0143***

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