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", 15 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.

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.

March 23, 2010			**Renewal**		
	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	_____	_____

Signed: _____ Group #: _____

_____ Group Telephone#: _____

(Print name of signature)

Title: _____ Date: _____

Email: _____

Please fax to 803-264-0143

FI