Attestation Regarding Employer Contribution – Fax to 803-714-6461

I, ____________________________ (Name), as authorized representative of ______________________ (Employer), hereinafter "the Employer", do hereby attest that the Employer Group Health 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 BlueChoice HealthPlan of South Carolina, hereinafter "BlueChoice", 20 days prior to the Plan renewal date will result in the loss of grandfathered status for the Plan and that BlueChoice will add additional health care reform requirements pursuant to PPACA which may cause an increase in premium.

Employer will immediately notify BlueChoice of any change in the Employer's contribution amount. Employer will indemnify BlueChoice for any liability related to a change in the Plan's grandfathered status that arises out of the Employer's contribution amount.

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	________	________

EMPLOYER:

By: ______________________________ Group #: ______________________________

Title: ______________________________ Group Telephone#: ______________________________

Address: ______________________________ Date: ______________________________

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