



STATE OF SOUTH CAROLINA
DEPARTMENT OF CONSUMER AFFAIRS

PROFESSIONAL EMPLOYER ORGANIZATIONS

Mailing Address
P.O. Box 5757
Columbia, SC 29250-5757

S.C. Code Ann. § 40-68-10 et seq.
www.consumer.sc.gov
(803) 734-4200

Street Address
2221 Devine St. Suite 200
Columbia, SC 29205

HEALTH INSURANCE AFFIDAVIT OF INSURANCE

(To be completed by Health Insurance Carrier)
(Please type or print in black ink)

Name of Affiant: _____

Name of Health Insurance Carrier: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Telephone No: _____ Fax No.: _____

E-Mail Address: _____ Web Site: _____

Affiant's Position with Health Insurance Carrier: _____

Name of Professional Employer Organization: _____

Health Insurance Policy Number: _____ FEIN #: _____

After being duly sworn upon my oath, I depose and declare that:

1. I am employed by the insurance carrier in the position listed above, and I possess the authority to make the following statements on behalf of that insurance carrier and to bind that insurance carrier concerning the statements made herein.
2. It is my understanding that, as a requirement for licensure as a Professional Employer Organization (PEO) in South Carolina, a PEO may not sponsor a plan for health insurance which is partially insured or self-insured, or a plan that is not licensed by the South Carolina Department of Insurance.
3. The above listed Health Insurance policy is a fully-insured insurance product, and the above-listed insurance carrier is licensed to provide this policy by the South Carolina Department of Insurance. Further, the above listed insurance carrier acknowledges that it is ultimately fully responsible for all incurred claims under the terms of this policy.

AFFIDAVIT

I swear or affirm and certify that I have completed and/or reviewed all information submitted on this form, and to the best of my knowledge and belief, all information contained herein is true, correct and complete; and that there are no material omissions of fact which would have a bearing upon the South Carolina Department of Consumer Affairs' decision to grant the requested license. I further certify that I understand that giving false information constitutes cause for denial or revocation of the application and subjects me to criminal prosecution for perjury. I acknowledge that I have a duty and agree to update and correct this information as it changes.

Signature

Date

SWORN TO AND SUBSCRIBED before me

this _____ day of _____, 20_____

Notary Public For _____

(SEAL)

My Commission Expires:

Do not fax this form. An original, signed and notarized form is required.

The South Carolina Freedom of Information Act may require the Department of Consumer Affairs to release this form as a public record; however personal identifying information will be released only if required by law.