



#### Section IV: Funding

Indicate from which of the following sources you receive funding. Check and list all that apply.

- Public sources only      Type of funding: \_\_\_\_\_
- Private sources only      Type of funding: \_\_\_\_\_
- Public and private sources      Type of funding: \_\_\_\_\_

#### Section V: Other participation in PEBA-administered benefits programs

Does the Employer participate in the South Carolina Retirement Systems?

- No     Yes    If yes, what is the Employer Code? \_\_\_\_\_

Has the Employer previously participated in the State Insurance Benefits Program?

- No     Yes    If yes, what was the Group Number? \_\_\_\_\_

Date of termination of prior coverage: \_\_\_\_\_

#### Section VI: Requested effective date for coverage

Indicate the Employer's requested effective date for coverage under the State Insurance Benefits Program. This date should be at least six months from the date of this request. \_\_\_\_\_

#### Section VII: Authorized person information and certification

Name of authorized person submitting this request:

Title/position:

Phone number:

Email address:

*My signature below certifies that I am authorized to make this eligibility request on behalf of my employer's governing body and that all information provided herein is true and correct to the best of my knowledge.*

Signature of authorized person: \_\_\_\_\_ Date: \_\_\_\_\_