



Employee Benefits Services Authorizing Agent Designation

I hereby designate _____ as the authorizing agent of
(Authorizing agent name)

(Participating entity name)

BIN: _____ Last four digits of SSN: _____

Email address: _____

The above-named authorizing agent will control access of this organization's employees and its third-party enrollers to the South Carolina Public Employee Benefit Authority's Employee Benefits Services (EBS) web-based application. The above-named authorizing agent is authorized to execute *Designated Employee Confidentiality Agreements* on behalf of this organization.

Participating entity name: _____

Employer group number: _____

Printed name: _____

Signature of director/CEO: _____ Date _____