PEBA℠
SC Retirement Systems and State Health Plan

Optional Employer Eligibility Determination Request for Participation in the State Insurance Benefits Program

Complete the form below and return via email to EmployerServices@peba.sc.gov.

Note: PEBA will use the entity's legal name for official business.

Section I: Employer information

Legal name of employer:		
Common/business name (if applicable):		
Federal tax ID number:	State tax ID number:	
Mailing address:		
City:	State:	Zip:
Street address:		
City and county:	State:	Zip:

Type of employer: ☐ Municipality ☐ County ☐ Special purpose district
☐ Other political subdivision (describe): _____
☐ Governmental agency/instrumentality (describe): _____

Section II: Employee information

Number of employees:	Total number of covered lives:

Number of covered lives in each of the following categories:

_____Active employees	_____Dependents of active employees
_____Retired employees	_____Dependents of retired employees
_____Former employees on COBRA	_____Dependents on COBRA
_____Survivors of deceased employees	_____Former spouses

Section III: Governance

Describe the composition of the Employer's governing body (e.g., board, commission, etc.).

Are the members of the governing body elected or appointed? ☐ Elected ☐ Appointed	If the members are elected or appointed, by whom or which authority?_____

Describe the Employer's enabling authority. Attach copies of the relevant creation and governance documents (e.g., statutes, ordinances, charters, articles of incorporation and bylaws).

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: _____