SOUTH CAROLINA BUDGET AND CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM

REQUEST FOR ACCOUNTING OF DISCLOSURES

INSTRUCTIONS:
Complete this form, or submit the information requested in any other written form to:

Director
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, SC 29211

The Employee Insurance Program has 60 days from receipt to respond to your request, and an additional 30 days may be needed to complete your request. An administrative fee may be charged for more than one request in a 12-month period.

Name: _____ Benefits Identification Number:_____

Address: _____
(Street, P. O. Box)

_____
(City, State, Zip Code)

Telephone Number: _____ Date: _____

Please indicate the range of dates for which you want an accounting.

From: _____/_____/_____ To: _____/_____/_____
MO DAY YR MO DAY YR

Please indicate how you want the list compiled.

Paper: _____ Electronic: _____ Other (Specify): _____

Signature: _____

BCB-EIP Form 02-11-3