

## South Carolina Health Insurance Pool (SCHIP) Assessment Base Reporting Form

<p>This form must be completed and submitted, postmarked by <b>MARCH 1, 2026</b>, by any insurer licensed to write accident and health insurance in South Carolina, even if all amounts are zero.</p>	<p>Submit by <b>MARCH 1, 2026</b>, to:  <b>John Hoodenpyl, AX-555</b>  <b>BlueCross BlueShield of SC</b>  <b>I-20 at Alpine Road</b>  <b>Columbia, SC 29219</b>  <b>Tel (803) 264-5458</b>  <b>E-mail John.Hoodenpyl@bcssc.com</b></p>	<p>Please submit <b>ORIGINAL</b> signed form to the address shown and <b>NOT</b> to the South Carolina Department of Insurance. Please send via regular mail or email signed pdf copy to John Hoodenpyl.</p>
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**1. TOTAL 2025 DIRECT A&H PREMIUMS WRITTEN IN S.C.** \$ \_\_\_\_\_  
*(Should agree with total direct A&H premiums written in South Carolina as shown on the State Page or Schedule T of the Annual Statement.)*

**2. PREMIUMS EXCLUDED FROM SCHIP ASSESSMENT:**  
*(Deduct only to the extent included in line 1 above.)*

- (a) Coverage only for accident or disability income insurance, or any combination thereof \$ \_\_\_\_\_
- (b) Credit-only A&H insurance \$ \_\_\_\_\_
- (c) Coverage for on-site medical clinics \$ \_\_\_\_\_

**If offered separately:**

- (d) Limited scope dental or vision benefits \$ \_\_\_\_\_
- (e) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof \$ \_\_\_\_\_

**If offered as independent, noncoordinated benefits:**

- (f) Coverage only for a specified disease or illness \$ \_\_\_\_\_
- (g) Hospital indemnity or other fixed indemnity insurance \$ \_\_\_\_\_
- (h) If offered as a separate insurance policy, coverage supplement to coverage provided under Chpt 55, Title 10 of the U.S. Code (i.e., Tricare supp) \$ \_\_\_\_\_
- (i) Federal Employees Health Benefit Program \$ \_\_\_\_\_
- (j) Medicare Adv, MAPD, PD (Note: Med supp premiums are not excluded.) \$ \_\_\_\_\_
- (k) Medicaid and State Children's Health Insurance Program \$ \_\_\_\_\_
- (l) TOTAL EXCLUSIONS Add lines 2(a)-2(k) \$ \_\_\_\_\_

**3. 2025 SCHIP ASSESSMENT BASE** Subtract line 2(l) from line 1 \$ \_\_\_\_\_

Does your company write individual major medical insurance in South Carolina?  
 \_\_\_\_\_ Yes      \_\_\_\_\_ No      2025 S.C. Individual Major Med Premium \$ \_\_\_\_\_  
 Check here if through a group trust/assoc \_\_\_\_\_

I certify that this information is correct and that these figures accurately reflect premiums written in South Carolina during 2025. I also understand that the amount on line 3 above will be used to determine my company's share of assessments made for losses of the South Carolina Health Insurance Pool.

Company Name \_\_\_\_\_ NAIC Code No \_\_\_\_\_

Signature of Authorized Officer \_\_\_\_\_ Date \_\_\_\_\_

Typed/Printed Name of Officer \_\_\_\_\_

Officer Email Address \_\_\_\_\_

**Contact person for this form:**

**Person to receive assessment notices:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

Group \_\_\_\_\_

Group \_\_\_\_\_

Distribution \_\_\_\_\_

Distribution \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_