



MADISON COUNTY BOARD OF SUPERVISORS

125 West North Street • Post Office Box 608
Canton, Mississippi 39046
601-855-5500 • Facsimile 601-855-5759
www.madison-co.com

September 4, 2018

Pete Hawkins, Accounting Executive
Blue Cross & Blue Shield of MS
PO Box 2312
Jackson, MS 39225-2312

Dear Sir:

Please find our accompanying Group Termination Form. This confirms our intention to discontinue our use of your third-party claim administration services. The date of termination is 9/30/2018.

We acknowledge that claims filed before the termination date will continue to be processed by you and expect a claim run-out period of approximately 90 days. This time period may require adjustment based on circumstances with specific claims.

Additionally, it is our expectation that rebates on pharmaceutical purchases by our plan may not be received or processed until after the termination date. As we will be responsible for such claims, we also expect to receive credit or payment for any rebates received after termination.

We appreciate the cooperation and service that you have given to us as our third-party claims administrator.

Sincerely,

Sheila Jones, Board President
District 1
Madison County Board of Supervisors



BlueCross BlueShield of Mississippi

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

GROUP TERMINATION FORM

Group Information

Legal Group Name (as it appears on your bill) and Physical Address:

Madison County Board of Supervisors 125 W. North Street Canton, MS 39046

Benefit Plan Type Requested for Termination

Medical Group Number

#048887 & 048888

Requested Effective Date of Termination

09/30/2018

Dental Group Number

Requested Effective Date of Termination

Life Group Number

Requested Effective Date of Termination

If terminating more than one benefit plan type under each group plan, please list all applicable group numbers. This should include COBRA and/or State Continuation of Coverage group numbers.

Termination Reason

Provide the reasons for terminating your group coverage.

Change health insurance provider.

Sheila Jones
Name of Authorized Group Contact

August 28, 2018
Date

Signature of Authorized Group Contact

Date