

# PROPRIETOR/PARTNER/ CORPORATE OFFICER ELIGIBILITY STATEMENT

Proprietor, partner, or corporate officer name (please print): \_\_\_\_\_

**COMPANY INFORMATION**

Company name		Customer ID (if assigned)	
Phone (       )       -	Ext.	Fax (       )       -	

**ELIGIBILITY ATTESTATION**

If you are a proprietor, partner, or corporate officer who is not listed on the DE 9C (Quarterly Contribution Return and Report of Wages), please complete this form to establish your relationship to the company referenced above.

1. I attest that, although my name does not appear on the DE 9C of the above-named company, the following is true:
  - a. I am a sole proprietor, partner, or LLC manager/member of the above-named company.
  - b. I actively work at this company on a permanent basis with a normal work week of (check one):
    - 20 to 29 hours per week
    - 30 or more hours per week
  - c. I draw wages, dividends, or other distributions from this company on a regular basis.
  - d. I do not derive substantial earned income from any other employer and am not eligible for other employer-sponsored coverage as a subscriber.
  - e. I will have satisfied the designated waiting period before coverage becomes effective.
  
2. I will provide additional ownership/business validation documentation, including the appropriate IRS forms, as requested.

**Note: Kaiser Permanente reserves the right to ask for additional documentation as circumstances warrant.**

**SIGNATURE**

By signing this form, I acknowledge that this information may be subject to verification and agree to provide Kaiser Permanente with any information necessary to do so. I also understand that failure to meet the above conditions may result in denial or termination of group health coverage for the above-named company.

Proprietor, partner, or corporate officer name (please print)	Title (please print)
Signature <b>X</b>	Date