



Small Business  
**PROPRIETOR/PARTNER/  
CORPORATE OFFICER ELIGIBILITY STATEMENT**

Use beginning May 2012

**COMPANY INFORMATION**

Company name	Customer ID (if assigned)
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**ELIGIBILITY ATTESTATION**

If you are a proprietor, partner, or corporate officer who is not listed on the DE 9C, 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 (Quarterly Contribution Return and Report of Wages) 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. If my eligibility is required to meet the minimum group size requirement to qualify for small business coverage, I attest to working the prescribed minimum hours per week for at least six weeks.
  
3. I will provide additional ownership/business validation documentation, including the appropriate IRS forms, as requested.

**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
Signature <b>X</b>	Date