KAISER PERMANENTE®

Small Business Accounts

PROPRIETOR/PARTNER/CORPORATE OFFICER ELIGIBILITY STATEMENT

Company name (please print)	**Customer ID***

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 above-referenced company.

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, corporate officer, or LLC manager/member of the above-named company.

b. I actively work at this company on a permanent basis with a normal workweek of:

☐ 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.

By signing this form, I acknowledge that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan, Inc., 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 from Health Plan for the above-named company.

Proprietor, partner, or corporate officer name (please print)	**Title**
Signature (use black ink) **X**	**Date**

*Leave blank if your group has not yet been assigned a customer ID.

Small Business Marketing
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