# Eligibility Statement

## Sole Proprietor, Partner, or Corporate Officer

### **Section A** – Company Information

**Sole Proprietor, Partner, or Corporate Officer Name**

**Company Name** | **Federal Employer ID Number** | **Company Phone**

**Street Address** | **City** | **County** | **State** | **ZIP**

### **Section B** – Eligibility Attestation

**I attest that, although my name may not be listed on the DE-9C wage report for the above-named company, the following is true:**

1. I am a sole proprietor, partner, or corporate officer in the above-named company.
2. I actively work for the above-named company on a permanent basis with a normal work week of (select one):
   - ☐ 20 to 29 hours
   - ☐ 30 or more hours
3. I draw wages, dividends or other distributions from the above-named company on at least a monthly basis.
4. I am not eligible for group health coverage from any other employment.
5. I will have satisfied the designated waiting period before coverage becomes effective, if applicable.

### **Section C** – Documentation

**The above-named sole proprietor, partner, or corporate officer must appear on the following applicable documents (select one):**

| | |
|---|---|
| ☐ Sole Proprietor | Current California Business License, Fictitious Business Name Filing, or Current Schedule C and Form 1040 |
| ☐ Partner | Partnership Agreement and Federal (EIN) Assignment Letter, Current Schedule K-1 (1065), or Statement of Partnership Authority |
| ☐ Corporate Officer | Articles of Incorporation, Statement of Information, Schedule K-1 1120S (for S Corp), or Tax Form 1120 (pages 1 and 2) with Schedule 1125e (for C Corp) |

*Sutter Health Plus reserves the right to ask for additional documentation as circumstances warrant.*

### **Section D** – Signature

I understand that this information may be subject to verification and agree to provide Sutter Health Plus with all information necessary to prove the above statements. I also understand that failure to meet the above conditions may affect eligibility for coverage.

**Name of Sole Proprietor, Partner or Corporate Officer** *(please print)*

**Title** *(please print)*

**Signature of Sole Proprietor, Partner or Corporate Officer**

**Date**

*Groups with less than five employees enrolled must provide proof of eligibility for each owner as requested.*

**Fax or email completed form to:**
Fax: 916-736-5418
Email: shpsales@sutterhealth.org

Sutter Health Plus
Your Health Plan