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: **shpserviceteam@sutterhealth.org**

Sutter Health Plan