

COMPANY INFORMATION

Company name

Customer ID (if assigned)

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

Date

X