## SOLE PROPRIETOR, PARTNER, OR CORPORATE OFFICER

# STATEMENT

**Small Group requirements for proof of eligibility when no DE-6 available or if not listed on DE-6**

I attest that while I am not listed on the DE-6 wage report of this company, all of the following conditions are true:

1. I am a sole proprietor, partner or corporation officer of the company name indicated below; and
2. I am actively at work at this company; and
3. I draw wages, dividends or other distributions from this company on a regular basis, and do not derive substantial earned income from any other employment; and
4. I work a minimum of 20 hours per week for this company on a permanent and full-time basis; and
5. I have satisfied the designated waiting period before health insurance coverage is to become effective.

**PLEASE PRINT**

| Name | Phone No. ( ) |
|---|---|
| Title | Percentage of Ownership in Firm % |

Company Name

Address

City / State / ZIP Code

**CHECK ONE OF THE FOLLOWING:**

**SMALL GROUP REQUIREMENTS FOR PROOF OF ELIGIBILITY:**
*(Anyone enrolling must appear on the following documents)*

☐ **SOLE PROPRIETOR** ..... **Submit one of the following documents:**
California Business License, ***or***
Fictitious Business Name Filing, ***or***
Current Schedule C

☐ **PARTNER** ..... **Submit one of the following documents:**
Partnership Agreement, ***or***
Current Schedule K-1
*The limited partners in a limited liability partnership are not eligible for coverage unless they are also employees appearing on the DE-6.*

☐ **CORPORATE OFFICER** ..... **Other legal documentation may be requested such as:**
Statement by Domestic Stock Corporation, ***or***
Articles of Incorporation
For out-of-state corporations:
- Certificate of Qualification, ***or***
- Statement by Foreign Corporation

I understand this information may be subject to audit and agree to provide Blue Cross of California, or its affiliates, with any and all information and documentation necessary to prove the above statements. I also understand that any misrepresentation by me of my true circumstances may result in recision of group health coverage from Blue Cross of California, or its affiliates, Small Group Health Plan for myself, my enrolled dependents and/or this company as Blue Cross of California, or its affiliates, may choose. Blue Cross of California, or its affiliates, also expressly reserve any other rights and remedies.

**Signature:** X_____ **Date:** _____

Blue Cross of California is an Independent Licensee of the Blue Cross Association ® is a registered mark of the Blue Cross Association. The Basic Hospital Plan, the Dental PPO/FFS Plans and Life/AD&D Insurance are written by BC Life & Health Insurance Company. Other medical coverages and Dental Net are written by Blue Cross of California Workers' Compensation provided by Fremont Compensation Insurance Company.