

Proprietor/Partner Form



(If not listed on DE-6)

I attest that, although my name does not appear on the DE-6 wage report of the below-named company, the following conditions are true:

1. I am a sole proprietor or partner of a partnership;
2. I am actively at work at the below-named company;
3. I draw wages, dividends, or other distributions from the below-named company on at least a monthly basis and am not eligible for group health coverage from any other employment.
4. I work on a permanent, full-time basis for the below-named company for at least 20 hours per week.
5. I have satisfied the designated waiting period before coverage is to become effective.
6. I must provide, upon request from Kaiser Permanente, a copy of my company's fictitious name statement, DBA or partnership documents.

I understand that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan with any information necessary to do so. I also understand that failure to meet the above conditions may result in rejection or non-renewal of group health coverage from Kaiser Foundation Health Plan for the below-named company.

Proprietor or Partner's Signature

Date

Print Proprietor or Partner's Name

Title

Company Name