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