SOLE PROPRIETOR, PARTNER OR CORPORATE OFFICER

STATEMENT

Small Group requirements for proof of eligibility for owners/officers 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.

Name *(Please Print)*	
Title	Percentage of Ownership in Firm (if applicable) %
Company Name	

CHECK ONE OF THE FOLLOWING: SMALL GROUP REQUIREMENTS FOR PROOF OF ELIGIBILITY:
(Anyone enrolling must appear on the following documents)

☐ SOLE PROPRIETOR

Current Schedule C (If not available due to the length of time in business or due to having received an extension to file, a California Business License or Fictitious Business Name filing may be substituted.)

☐ PARTNER

Current Schedule K-1 (If not available due to the length of time in business or due to having received an extension to file, a Partnership Agreement and Federal Tax ID appointment letter may be substituted.)

The limited partners in a limited partnership are not eligible for coverage unless they are also employees appearing on the DE-6.

☐ LIMITED LIABILITY COMPANY (LLC) MEMBER

Current Schedule K-1 (If not available due to the length of time in business or due to having received an extension to file, a Statement of Information or Articles of Organization with Operating Agreement may be substituted.)

☐ CORPORATE OFFICER

Statement of Information and/or Statement by Domestic Stock Corporation or **Articles of Incorporation** (filed and stamped listing names of all officers)

Statement of Foreign Corporation (for out-of-state corporations)

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 (BCC) and BC Life & Health (BCL&H) Insurance Company are Independent Licensees of the Blue Cross Association (BCA).
The Blue Cross name and symbol are registered service marks of the BCA.