

## Small Business Proprietor/Partner/Corporate Officer Eligibility Statement

Company Owner/Officer (please print)	
Company name	Percentage of ownership in firm*

\* If the percentage of ownership is zero, the enrollee must appear on the Quarterly State Tax Withholding Report.

If you are a proprietor, partner, corporate officer, or LLC manager/member who is not listed on the Quarterly State Tax Withholding Report, 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 Quarterly State Tax Withholding Report of the above-named company, the following is true:
  - a. I am a sole proprietor, partner, corporate officer, or LLC manager/member of the above-named company.
  - b. I am actively at work at this company working an average of 30 hours per week over the course of a month on a permanent and full-time basis.
  - c. I draw monetary compensation 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.
2. I will provide additional ownership/business validation documentation, including the appropriate IRS forms, as requested.
3. If my eligibility is required to meet the minimum group size to qualify for Small Group business coverage, I additionally attest that:
  - I do not wholly own the above-named company with my spouse/domestic partner or on my own;
  - I am not a partner in a partnership;
  - I am not a 2-percent S corporation shareholder; and
  - I am not a worker described in Section 3508 of Title 26, Internal Revenue Code.

Additional attestation for owner of multiple entities:

If I am an owner of multiple entities, I have designated this entity as the sole entity for which I am eligible as an owner for Anthem Blue Cross coverage.

I understand this information may be subject to audit and agree to provide Anthem Blue Cross, 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 termination of group health coverage from Anthem Blue Cross, or its affiliates, Small Group Health Plan for myself, my enrolled dependents and/or this company as Anthem Blue Cross, or its affiliates, may choose. Anthem Blue Cross, or its affiliates, also expressly reserve any other rights and remedies.

Signature X	Date
----------------	------