Health Net of California, Inc. (Health Net)

Proof of Eligibility Statement

For sole proprietor, partner or corporate officer

This form must be completed to demonstrate proof of eligibility for small group coverage for owners/officers when no DE-9C wage report is available or if it is not listed on the DE-9C.

Please note: This form is only for groups of 25 or more active subscribers for sole proprietors, partners or officers to submit in lieu of ownership documentation.

I attest that while I am not listed on the DE-9C wage report of the below-named company, ALL of the following conditions are true:

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

Please print

Proprietor, partner or corporate officer's name:	Title:	
Company name:	Percentage of ownership in firm (if applicable):	
Company address:		
City:	State:	ZIP:

Agreement

I understand that this information may be subject to audit and agree to provide Health Net, or its affiliates, with documentation and/or any information necessary to prove the above statements. I also understand that any misrepresentation by me or failure to meet the above conditions may result in rejection of the application, recision or nonrenewal of group health coverage from Health Net, or its affiliates, for myself, my enrolled dependents and/or the above-named company as determined by Health Net or its affiliates.

Proprietor, partner or corporate officer's signature:	Date:

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