

Company name _____ Group number _____

Please fill out this form for any proprietor, partner, or corporate officer not listed on the DE 6.

To establish the relationship between proprietors, partners, and/or corporate officers to the above-referenced company, please complete and return this form using black ink.

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

1. I am a sole proprietor, partner of a partnership, or corporate officer.
2. I actively work at the above-named company.
3. I draw wages, dividends, or other distributions from the above-named company.
4. I work on a permanent, full-time basis for the above-named company for at least 20 hours per week.
5. I satisfied the designated waiting period before coverage became effective.
6. I must provide, upon request from Kaiser Permanente, a copy of my company's DBA fictitious business name statement, legal partnership agreement and Schedule K-1, articles of incorporation, Schedule C, current business license, or current professional license.

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

X _____
Proprietor, partner, or corporate officer's signature

Proprietor, partner, or corporate officer's name
(please print)

Title

Date

X _____
Proprietor, partner, or corporate officer's signature

Proprietor, partner, or corporate officer's name
(please print)

Title

Date