

Proof of Eligibility Statement

For household employers

This form must be completed to demonstrate proof of eligibility for small group coverage for eligible owners when not earning full-time wages

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 the employer of the below-named business; and
2. I am actively at work at the below-named business; and
3. I do not derive substantial earned income from any other employment and am not eligible for other employer-sponsored coverage; 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 business at least the minimum number of weekly hours indicated on the Application for Group Service Agreement.

Please print

Eligible owner's name:	Title:	
Business name:		
Business 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, rescission 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.

Employer's signature:	Date:
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