

# Sole Proprietor/Owner/Partner Statement



I attest that, although I am not listed on the DE-6 wage report of the below named company, the following conditions are true:

1. I am a sole proprietor, owner or partner of a partnership;
2. I am actively at work at the below named company;
3. I draw wages, dividends or other distributions from the below named company on at least a monthly basis;
4. I am not eligible for group health coverage from any other employment;
5. I work on a permanent, full-time basis for the below named company at least 20 hours per week;

I understand that this information may be subject to verification and agree to provide Western Health Advantage with information necessary to prove the above statements. I also understand that failure to meet the above conditions may result in rejection or non-renewal of group health coverage from Western Health Advantage for the below named company.

Company Name \_\_\_\_\_

Title \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_