Start-up/Spin-off Companies
Small Business Eligibility Statement

Company name:

Entity type: ☐ Sole proprietor ☐ Corporation ☐ LLC ☐ Partnership ☐ LP ☐ LLP ☐ Other

Start-up/spin-off companies:

If you are a shareholder, member, officer, or have ownership stake in this company and are not listed on the Quarterly State Tax Withholding report, payroll, or have not yet taken a draw from this company due to the start date of the business:

1. I attest that the following is true:
   a. I am a shareholder, member, officer, or have an ownership stake in 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 am a small business employer and employ at least one common-law employee who qualifies as an eligible employee.
   d. I have been in business and hired my first eligible employee within the last six weeks. (For purposes of determining whether an employer has one employee, sole proprietors and their spouses or domestic partners, and partners of a partnership and their spouses or domestic partners, are not employees.)
2. I will provide additional ownership/business validation documents, including the appropriate IRS forms, as requested.

Spin-off companies:

A "spin-off group" is a newly formed business in which a majority of the employees of the new business have left an established business ("former business") currently offering Blue Shield coverage to its employees.

1. In addition to the above statements, I attest that the following is true:
   a. At least 50% of the employees in the spin-off must have been enrolled in Blue Shield through the former business.
   b. The new business does not have shared ownership with the business it has separated from.

I understand that this information will be subject to recertification (audit) at renewal and agree to provide Blue Shield of California, 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 Blue Shield of California, or its affiliates, Small Business health plan for myself, my enrolled dependents, and/or this company.

Owner signature

Date

Owner name (please print)