We want you to know™
Aetna

Proof of Eligibility Form

Small Employers with 50 or fewer eligible employees
Sole Proprietors, Partners or Corporate Officers
(To be used for eligible individuals that are not reported on a quarterly wage and tax form)

Full Name (First, MI, Last)	Phone No.
Title	Percentage of Ownership in Firm
Date of Hire	Number of hours worked per week
Company Name	

In order to satisfy the Small Employer Requirements for Proof of Eligibility, *the following most recent IRS Tax documents are required*. (Anyone eligible must appear on the below documents .)

Please check one of the following:		**Must submit one of the following identified documents :**
❑	C-Corporation	➢W2
❑	S-Corporation	➢IRS Form 1120 S Schedule K-1 along with Schedule E (Form1040)
❑	Partnership	➢IRS Form 1065 schedule K-1; or ➢IRS Form 1120S Schedule K1 along with Schedule E (Form1040)
❑	Limited Liability Company (LLC)	➢May file as either C Corporation or Partnership
❑	Sole Proprietor	➢IRS Schedule SE and Schedule C filed with Form 1040; or ➢IRS Form 1040 Schedule F or K1

I attest that while I am not listed on the state quarterly wage and tax statement for this company, the following are true (check applicable boxes):

❑ 1. I am a sole proprietor, partner or corporation officer of the company indicated above.

❑ 2. I am actively at work at this company on a full time, permanent basis working no less than the minimum number of hours required by the applicable State Laws.

❑ 3. I draw wages, compensation, dividends or other distributions from this company on a regular basis and do not derive substantial earned income from any other employment.

❑ 4. I have satisfied the designated waiting period before health insurance coverage is to become effective.

❑ 5. I am a retiree of the above company and qualify for benefits under their guidelines.
(Retiree coverage is only available in states where mandated. Maine and New Hampshire - all groups. Florida and Illinois - municipalities only.)

I understand this information may be subject to audit and agree to provide Aetna and/or its affiliates, with any and all information and documentation necessary to validate the above statements. I also understand that any misrepresentation by me of my true circumstances may result in the termination of group health coverage from Aetna and/or its affiliates, for me, my enrolled dependents and or this company as Aetna and/or its affiliates may choose. Aetna and/or its affiliates also expressly reserve any other rights and remedies.

It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature _____ Date _____