Business Attestation Form
For
Sole Proprietor or Business where the Owner is the Sole Employee
Partnerships with No Employees

Business Organization Information:

Name of Organization: _____

State Business License #: _____

Primary Business Activity: _____

Address: _____

City:_____ State:_____ Zip: _____

Contact Information for Business Organization

Name: _____

Title: _____

Phone Number: _____Fax: _____

Check one below:

☐ **Sole Proprietor or Business where the Owner is the Sole Employee**. I hereby attest that: (i) I am the owner and operator of the above described business organization; (ii) I work a minimum of thirty (30) hours per week for this business organization; (iii) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization.

☐ **Partnership**. I hereby attest that: (i) I am one of the owners of the above described business organization and have the authority to enter into an agreement to purchase health insurance coverage on behalf of all of the partners of this business organization; (ii) the above business organization does not offer health insurance coverage to any of the partners through another company; (iii) the above business organization does not have any "W-2" employees; (iv) only the partners that work a minimum of thirty (30) hours per week for this business (and their eligible dependents) will seek health coverage through the organization.

☐ **None of the Above**. If the above does not describe you, check here; no signature is needed.

I agree to provide upon request appropriate tax forms to Hometown Health to validate the eligibility status. Before application will be approved, the applicant must execute this Attestation Form and provide the tax information and related documents indicated on the attached checklist. Hometown Health reserves the right to modify these documentation and eligibility requirements in the future. I agree to promptly advise Hometown Health in the event that any of the statements made in this Attestation are no longer accurate. The undersigned certifies that, to the best of his or her knowledge and belief, and under penalty of perjury, the information listed above is true and complete.

_____ _____

Signature of Applicant Date