

F O R M

PARTNERS, OFFICERS OR OWNERS VERIFICATION FORM

_____ (Hereafter referred to as "The Employer") certifies that _____ ("The Employee") is a bona fide Full-Time employee of _____, (Company Name), in the capacity of _____ (Partner, Officer or Owner).

"The Employer" certifies that "The Employee" works a minimum of _____ hours per week and does not appear on The Quarterly Wage and Tax statement because he/she receives compensation as follows: _____

As an authorized officer of "The Employer" I, _____, hereby accept accountability for the verification of the provided information as truthful. Should HealthPass discover that "The Employee" is not employed Full-Time, a termination of the group from coverage will ensue the end of the month in which the discoveries are made.

In the event "The Employee" no longer meets the minimum eligibility requirements, Healthpass will be notified immediately.

Signature and Title

Date

Witness (Signature)

Date