Full-Time Status Certification for Owners, Partners, Proprietors
(To be used for full time eligible persons not listed on the State Quarterly Wage/Tax Report)

____________________________(“Employer”) wishes to include owners, partners, and/or proprietors under the Employer’s Group Health Plan (“the Plan”) with Blue Cross and Blue Shield of Illinois (“BCBSIL”). Employer certifies that the following information is complete and accurate.

1. The individuals listed below are not on the Employer’s Payroll or Wage and Tax Report. The Employer certifies that each individual is actively at work for the Employer and is scheduled to work a minimum of 30 hours per week.

   ____
   (Print or type name and title)
   ____
   (Print or type name and title)
   ____
   (Print or type name and title)

2. The individuals above are compensated hourly, daily, weekly, monthly, quarterly, or annually as identified below. (Provide supporting documentation of compensation, such as a K-1, 1120S, etc)

_____________________________	________________________
(Print or type name)	(Compensation Interval)
_____________________________	________________________
(Print or type name)	(Compensation Interval)
_____________________________	________________________
(Print or type name)	(Compensation Interval)

3. The individuals listed below are not receiving any compensation or remuneration from the Employer.

_____________________________	___________________________________
(Print or type name)	(Indicate reason)
_____________________________	___________________________________
(Print or type name)	(Indicate reason)
_____________________________	___________________________________
(Print or type name)	(Indicate reason)

Employer understands and acknowledges that BCBSIL is relying on Employer’s certification for purposes of including Owners, Partners, and/or Proprietors in the Plan.

__________________________________	____________________
(Print or type Employer Name)	(Date)

____
(Print or type Name of Owner/Officer authorized to make certification)

____
(Signature of Authorized Individual)