COMMON GROUND
HEALTHCARE COOPERATIVE

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Eligibility Certification Form

Company/Employer Name: _____ Phone Number: (____)_____

Address: _____ City/State/ZIP Code: _____

This form should be used in addition to your quarterly state wage and tax report or payroll documents. Any employee not listed on the state wage and tax report or payroll documents *who is eligible for insurance coverage* must be included on this form.

Employee Name (First & Last)	Status Code*	Date of Hire	Hours Worked per Week	Employee Receives Wages that Meet State Minimum Wage Requirements	Comments
1.				☐ Does ☐ Does Not	
2.				☐ Does ☐ Does Not	
3.				☐ Does ☐ Does Not	
4.				☐ Does ☐ Does Not	
5				☐ Does ☐ Does Not	
6.				☐ Does ☐ Does Not	
7.				☐ Does ☐ Does Not	
8.				☐ Does ☐ Does Not	
9.				☐ Does ☐ Does Not	
10.				☐ Does ☐ Does Not	
11.				☐ Does ☐ Does Not	
12.				☐ Does ☐ Does Not	
13.				☐ Does ☐ Does Not	
14.				☐ Does ☐ Does Not	
15.				☐ Does ☐ Does Not	
16.				☐ Does ☐ Does Not	
17.				☐ Does ☐ Does Not	
18.				☐ Does ☐ Does Not	

* **STATUS CODE** – Use the following Letter Codes under "Status Code" above

FTP – Permanent Full-Time Employee in Probationary Period
CO – Employee under State or Federal Continuation
RE – Retired Employee
PAR – Partner/Owner/Corporate Officer
LO – Leave of Absence (medical or personal)

- **Owners, Partners and Officers of the Company** certify that all of the following are true:
  1. I am actively at work at this company on a full-time, permanent basis; and
  2. I draw wages, dividends, or other distributions from this company on a regular basis, and do not derive substantial earned income from any other employment; and
  3. I have satisfied the designated waiting period before health insurance coverage is to become effective.
- I certify that **All Other Employees** listed above are actively at work of a full-time, permanent basis or are otherwise eligible for insurance coverage per state and/or federal requirements.
- I certify that the information provided on this form can be substantiated by business documents. I understand that this information may be subject to audit and agree to provide documentation to confirm eligibility requirements upon request.
- I certify that I have read this document and that the information provided is accurate and complete. I understand that providing incomplete, inaccurate, or untimely information may void, reduce, or terminate any individual or group coverage or result in a premium increase.

_____ _____
Owner, Partner or Officer's Signature Title

_____ _____
Printed Name of Owner, Partner or Officer Date