

BUSINESS GROUP OF ONE STATEMENT

This form is needed to determine if a Business Group of One meets the definition of a “Small Employer” as set by Colorado Legislation for Business Groups of One.

- C corporation
- LLC corporation
- Partnership

“Business group of one” means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has gross income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated gross income from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual’s income for one year out of the most recent consecutive three-year period. For the purposes of this subsection (6), “substantial part of such individual’s income” means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one. “Business group of one” includes a full-time household employee who works twenty-four hours or more a week on a permanent basis as a household employee, if that employee has derived at least a substantial part of such employee’s earned income for one year out of the preceding three-year period from household employment, and if the employee’s employer, on at least fifty percent of the days in a normal work week during the preceding calendar quarter, employed at least one household employee.

The name of my business is: _____
 My business activity is: _____

- And I attest that I have carried on significant business activity for a period of at least 1 year prior to the date of this application for insurance coverage.
- The business activity has had gross income as indicated on form 1040, Schedule C F or SE or other forms recognized by the IRS for income reporting purposes, and has generated gross income from which I have derived at least a substantial part of my individual income for 1 year out of the most recent consecutive 3-year period.
- I have provided supporting IRS forms or other forms recognized for income reporting purposes.

I understand that if any of the foregoing is inaccurate or materially misleading, Company may not be eligible for small employer health coverage. I further understand that in the event PacifiCare determines coverage was issued on the basis of inaccurate or materially misleading statements contained herein, such coverage may be terminated or retroactively cancelled to the date of issuance or you may be subject to rate and/or benefit adjustments. In the event of such retroactive cancellation, all subscription payments made by Company shall be refunded, and all payments made to providers for services rendered on behalf of employees and their covered dependents shall be recovered from such providers, and all sums due to the providers shall then become the sole responsibility of the employees and/or the Company.

The form must be fully complete to be processed for coverage. The undersigned individual, who is an applicant for a business group of one, hereby attests as follows:

I attest that I work 24 hours or more per week on a permanent basis and I am:

- An individual
- A sole proprietor
- The only full-time employee of the following:
 - Nonprofit corporation
 - Sub S corporation (*continues in next column*)

Subscriber Signature	Date	Company Name
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Customer Service:
 800-877-9777 PacifiCare SignatureValueSM (HMO)/
 PacifiCare SignaturePOSSM
 800-659-2656 (TDD)
 866-316-9776 PacifiCare SignatureOptionsSM (PPO)
 866-867-0700 PacifiCare SignatureFreedomSM (SDHP)
 800-442-8833 (TDHI)
www.pacificare.com