

**Employer Group Enrollment Form for
Chambers/Associations and Payroll Administrators
Sole Proprietor**

Chamber/Association/Payroll Administrator Name: _____

Employer Group Name: _____

Employer Address: _____

Employer Telephone: _____ Contact Person: _____

Employer Federal ID No.: _____ Member of Chamber/Association since: ___/___/___

The following requirements apply to Sole Proprietors. A sole proprietor group is defined as an unincorporated business, partnership or corporation whose owner, partner, stockholder, as applicable is the only active employee.

To be eligible for enrollment as a sole proprietor, the following requirements must be met. The applicant must:

1. be a member of a Chamber/Association that meets BlueCross BlueShield eligibility criteria and the requirements of the Insurance Law;
2. if purchasing through a chamber/association group, the subscriber must have been a member for a period of sixty days prior to the effective date of the insurance policy;
3. demonstrate that the applicant is a bona fide sole proprietor through the documentation requirements set forth in the table below;
4. work at least twenty hours per week;
5. not be employed by another business that has additional employees or be enrolled in any type of health care coverage under another employer group.

New groups who have joined the chamber or association within the past 60 days can be set up at any time during the year. The appropriate documentation must be attached to this submission. All paperwork, including applications must be received by the **15th of the month** prior to the effective date.

Type of Group	Required Documentation
Sole Proprietor	1) Schedule C
Subchapter S Corporation w/Sole Employee	1) Copy of NYS-45-ATT-MN OR copy of pay stub OR estimated tax form 2) Schedule E
Other Incorporated Business w/Sole Employee	1) Copy of NYS-45-ATT-MN OR copy of pay stub OR estimated tax form 2) Form W-2 Annual Wage Statement OR Form 1099 with Federal Income Tax Schedule F
Business in Business Less Than One Year	1) Copy of cancelled Business Check OR copy of a business Bank Statement OR a Certificate of doing business OR Appropriate Tax Documents

By signing below the employer group or sole proprietor certifies that they meet the eligibility requirements to be enrolled. I certify that the above information is true and accurate to the best of my knowledge. I understand that enrollment is subject to BlueCross BlueShield of Western New York underwriting guidelines and the Group Health Care contract between the Chamber/Association and BlueCross BlueShield. I understand that BlueCross BlueShield will conduct annual audits to ensure compliance with enrollment guidelines, which may require us to provide verification of our being a legitimate employer and/or sole proprietor.

Employer's Signature

Date