



EMPLOYEE ELIGIBILITY CONFIRMATION FORM

**VIVA Health
Small Business Plan**

Name of Employer: _____

The following individuals are full-time (30 or more hours per week) employees of the above named employer and are therefore eligible for health coverage with VIVA Health

NAME OF EMPLOYEE	REASON NOT ON ONE OF THE FOLLOWING: WAGE & TAX FORM <u>OR</u> CURRENT BILLING
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

The following individuals are not full-time employees of the above named employer and are not eligible for health coverage with VIVA Health.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

I understand that a misrepresentation of any of the above information can result in a retroactive declination of coverage by VIVA Health.

Signed: _____
Name (Print): _____
Title: _____
Date: _____