2010 Group Enrollment Form

Group Enrollment Checklist:

- ☐ Complete all parts of this Group Enrollment form
- ☐ Review, sign and return this form to:
  Liazon
  Attn: BNP
  737 Main Street, Suite 200
  Buffalo, NY 14203

  Or Fax to: 888-810-1059, Attn: BNP
- ☐ Attach the appropriate tax form
  If you have employees: attach an NYS-45 (including employees' Social Security Numbers).
  If you have no employees: please attach the appropriate tax document for your type of business.

  Which tax documents have you submitted with this form?
  NYS-45 _____ 1120 _____ 1065-K1 _____ 1120S _____ Schedule C _____ Other: ____________
- ☐ Use the Benefits Funding Worksheet on page 3 of this form to indicate the amount of your employees' benefits you are funding for 2010

Tell Us About Yourself	
Name:	Date:
Title/Position:	
Phone:	E-Mail:

Questions? Call the Liazon Consumer Advocacy Team at 1-866-LIAZON-1 (1-866-542-9661).

Tell Us About Your Business

Business Name:

Business Address:

City: State: Zip:

Type of Business:

Name(s) of Business Owner(s)/Partner(s):

Key Contact Person: Phone: E-Mail:

List Any Subsidiaries

Subsidiary Name:	Address:	No. of Eligible Employees:

Are you a subsidiary? Yes _____ No _____ If yes, list parent company:

Do you have a Section 125 Plan (to make pretax deductions for benefits)? Yes _____ No _____

Benefits Eligibility

What are the benefits eligibility policies for your company?

Eligible employees include all those working at least: 20 hours _____ 30 hours _____ 40 hours _____ Other: _____

Waiting period for all new hires is 1st of the month following: 30 days _____ 60 days _____ 90 days _____ Other: _____

Waiting period for all rehires is 1st of the month following: 30 days _____ 60 days _____ 90 days _____ Other: _____

Waiting period for part-time employees who become full-time is 1st of the month following:
30 days _____ 60 days _____ 90 days _____ Other: _____

How many eligible employees do you have?

A) Total number of ALL active employees, owners, and partners: ______
B) Total number of eligible retirees: ______
C) Total number of COBRA participants: ______
D) Total active employees not eligible: ______
E) Total eligibles (E = A+B+C-D): ______
F) Eligibles declining due to a valid waiver*: ______
G) **NET ELIGIBLES** (G = E-F): ______
H) Total eligibles enrolling in a Univera plan: ______
I) Total Group Participation** (I = H/G): ______

**Note: All individuals who waive insurance must submit a waiver form. Valid waivers include (exclusively): (1)Coverage through a spouse with a commercial carrier or TRICARE, (2) coverage through a parent who has commercial coverage, and (3) retiree coverage of the employee through a commercial carrier.*
***Groups of 5 net eligibles and below must have 100% participation; groups of 6 net eligibles and above must have 75% participation.*

Please list all ELIGIBLE employees, owners, or partners not listed on your NYS-45 or other tax documentation.

Name	Status	Social Security Number
	New Hire ____ Owner ____ Partner ____ Retiree ____ COBRA ____	
	New Hire ____ Owner ____ Partner ____ Retiree ____ COBRA ____	
	New Hire ____ Owner ____ Partner ____ Retiree ____ COBRA ____	
	New Hire ____ Owner ____ Partner ____ Retiree ____ COBRA ____	

If you need more space, please attach a separate sheet.

Benefits Funding Worksheet

Through Liazon's award-winning Bright Choices™ portal, we're giving your employees decision support tools to help them select the benefits that are right for them based on cost and coverage. The program relies on a defined contribution strategy using dollar-amount allocations for funding employees' benefits. You can use this worksheet to determine how much money you will provide to your employees for their benefits for 2010.

☐ **I am a single employee/sole proprietor company.**
You can stop here, because you do not need to define benefits contributions for your employees.

☐ **I have employees.**
If you have employees besides yourself who receive benefits through your company, please provide the following information:

There are two alternatives for contributing to your employees' benefits. You can provide a single monthly contribution to cover all benefits, or you can make separate contributions by type of insurance.
Please select the approach you wish to use and provide the appropriate contributions:

The company will allocate a specific monthly amount *per employee* for ALL benefits:

	Monthly Contribution
Single	$
Family	$

OR
The company will allocate specific monthly amounts *per employee* for SELECTED benefits:

	Monthly Contribution		
	Medical	Dental	Vision
Single	$	$	$
Family	$	$	$

Which, if any, of the following benefits will be employer paid?

Employee Life and AD&D	Long Term Disability	Short Term Disability	Accident	Critical Illness & Cancer Benefit
Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___

Long Term Care	Tele-Medicine	Health Discount	Health and Wellness	Pet Insurance
Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___

I certify that, to the best of my knowledge and belief under penalty of perjury, the information listed on this form is true and complete.

X ____

Signature Date