



Chautauqua County Chamber of Commerce

Bright Choices™

Group Enrollment Form

Group Enrollment Checklist:

Complete all parts of this Group Enrollment form

Review, sign and return this form to:
Liazon
Attn: Chautauqua
737 Main Street, Suite 200
Buffalo, NY 14203

Or Fax to: 888-810-1059, Attn: Chautauqua

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 ____ 1020C ____ 1065-K1 ____ 1020S ____ 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 2009-2010

Tell Us About Yourself

Name:

Date:

Title/Position:

Phone:

E-Mail:

**Questions? Call Erin Andersen at 716-366-6200 or 716-484-1101,
or the Liazon Consumer Advocacy Team at 1-866-LIAZON-1 (1-866-542-9661).**

Benefits Funding Worksheet

Through Liazon's award-winning Bright Choices™ portal, the Chautauqua County Chamber of Commerce gives 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 2009-2010.

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	\$	\$	\$

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