



Chautauqua County Chamber of Commerce

Bright Choices™

Personal Enrollment Form

Alternative to using online portal

The primary method for benefits enrollment is the Bright Choices portal.

Go to: <http://www.myliazon.com>

Group Identifier: Given after your employer has enrolled your group

Username: First and last initials and the last 4 digits of your Social Security Number (no dashes or spaces)

Password: Your full 9-digit Social Security Number (no dashes or spaces).

This alternative paper form may be completed by employees who do not have online access.

Personal Information	
Employer: <input type="text"/>	Your Social Security Number: <input type="text"/>
Enrollment Type: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: ___ / ___ / ___ Date of Hire: ___ / ___ / ___
Benefits Start Date: <input type="text"/>	Last Name: _____ First Name: _____
	Street: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ E-Mail: _____

Dependents (attach a separate sheet of paper for additional dependents):

First and Last Name	Relationship	Date of Birth	Social Security No.
	<input type="checkbox"/> Spouse <input type="checkbox"/> Male <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Female		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		

Please continue to other side.

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

Benefits Information and Enrollment

All Benefits Selections Left Blank Will Be Treated As Waived Coverage.

Are you on Medicare? No Yes If Yes, please include your ID#: _____

If enrolling your spouse, is he/she on Medicare? No Yes If Yes, please include your ID#: _____

Have you been enrolled in another insurance policy in the last 63 days? No Yes

If Yes, please provide the following information about your previous coverage:

Insurance Company Name:	Beginning Date of Prior Coverage:
Insurance ID#:	Ending Date:

Will you/your dependents on this plan be simultaneously covered by another health plan? No Yes

If Yes, please provide the following information about the covered person(s):

Name (or "All"):	Insurance ID#:
Insurance Company Name:	Beginning Date of Prior Coverage:

Medical Insurance

Place an "X" in the box for the plan and coverage level you want.

	Co-Pay 1	Co-Pay 2	Hybrid 1	Hybrid 2	Hybrid 3	HSA 1	HSA 2	HSA 3
Single								
Family								

Health Savings Account (HSA)

To contribute to an HSA, you must enroll in a qualified HSA plan above.

I want to open an HSA. You will need to provide a separate KeyBank Application and Adoption form to open your account.

Dental Insurance

Place an "X" in the box for the plan and coverage level you want.

	Value	Basic	Enhanced
Single			
Single + Spouse			
Single + Child(ren)			
Family			

Vision Insurance

Place an "X" in the box for the plan and coverage level you want.

	Plan A	Plan B	Plan C
Single			
Family			

I certify that the personal information listed above is true, and that the indicated selections are my true final selections for benefits for 2009-2010.

X _____
Signature Date