Bright Choices® Benefits Exchange® — 2012

Group Enrollment Form

Group Enrollment Checklist:

- ☐ Complete all parts of this Group Enrollment form
- ☐ Review, sign and return this form to:

  Liazon
  Attn: Midwest
  737 Main Street, Suite 200
  Buffalo, NY 14203

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

- ☐ 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 ____ 1120S-K1 ____ 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

Tell Us About Your Business		
Member of Chamber/Association:		
Are you a Sole Proprietor (1 employee total) _____ or a Small Group (2-50 employees) _____		
Business Name:		
Business Physical Address:		
City:	State:	Zip:
Business Mailing Address (if different):		
City:	State:	Zip:
Type of Business:	SIC Code:	EIN/TIN#:
Name(s) of Business Owner(s)/Partner(s):		
Key Contact Person:		
Phone:	E-Mail:	

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

(continued from page 1)

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 _____

Type of group sponsor: Employer _____ Union _____ Trustees of Fund _____ Association _____ Other _____

Organization Type: State Gov't _____ Local Gov't _____ Church Group _____ Nonprofit _____ Trust_____ Publicly Traded Org _____

Privately Held Corp _____ Privately Held Non-Incorporated _____ Not-for-profit _____ Other _____

Are there any other health plans in place for your group? Yes _____No _____ If yes, type of plan(s) _____ # of employees enrolled _____

Group size for federal Mental Health Parity and federal medical loss ratio reporting number of total employees, at all locations, for the prior calendar year: (Letter A below): _____

Do you employ any Vermont residents who work at employer locations in Vermont, including telecommuters working from their home in Vermont? Yes _____ No _____ If yes, provide the number _____

Do you employ any other out-of-state residents who work at out-of-state employer locations other than Vermont? Yes _____ No _____ If yes, provide the number _____

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: Date of Hire ____ 30 days ____ 60 days ____ 90 days ____ Other: _____
- All rehires is 1st of the month following: Date of Hire ____ 30 days ____ 60 days ____ 90 days ____ Other: _____
- Part-time ee's who become full-time is 1st of the month following: Date of Hire ____ 30 days ____ 60 days ____ 90 days ____ Other: _____

How many eligible employees do you have?

A) Total number of ALL active employees, owners, and partners at all locations: _____
B) Total number of eligible full-time & part-time employees at all locations: _____
C) Total number of eligible retirees at all locations: _____
D) Total number of employees enrolled in COBRA at all locations: _____
E) Total eligible employees: (E = B + C + D) _____
F) Employees working at other locations not eligible for programs offered through our plan: _____
G) Eligibles declining due to a valid waiver*: _____
H) Retirees who are offered a Medicare Advantage or Retiree health plan group product _____
I) NET ELIGIBLES (I = E - F - G - H): _____
J) Eligible employees enrolling in group enrolling (excluding retirees) _____
K) Total Group Participation** (K = J / I): _____

Participation Requirements: 75% must participate. Note: Employer contribution must equal at least 50% of the single premium rate for all plans selected by any of your employees.

Employer Groups that Do Not Meet Participation Requirements: If a group cannot meet the required participation requirements Univera Healthcare Underwriting will consider approval of group health coverage if the employer contributes in accordance with one of the two following contribution strategies: 1. At least 50% of the premium for all rate tiers; or 2. At least 90% of the single premium and contributing that amount towards all rate tiers.

Employer Groups contributing 100% of Premium: If an employer contributes 100% of the premium, all eligible subscribers must be enrolled in the group plan. Waivers will not be accepted.

*Note: All individuals who waive insurance must submit a waiver form. Valid waivers include (exclusively): Coverage through Family Health Plus, Medicare (all types and with competitors), Medicaid, Healthy NY, VA. Coverage through a spouse with a commercial carrier or TRICARE. Coverage through a parent who has commercial coverage. Retiree coverage of the employee through a commercial carrier. Ineligible employees

Please list all ELIGIBLE employees, owners, or partners not listed on your NYS-45 or other tax documentation. Sole Proprietors must list themselves below as owner of business (must work at least 20 hrs/week to be eligible for insurance)

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.

Calendar Year Employer Contribution (for calendar year coverage is effective)

Please note, if your contribution amount/type changes, you are required to notify the Health Plan of these changes

Coverage Effective Date _____ Contribution Effective Date _____ Contribution End Date _____

Rate Tier:	Premium Contribution Type:	
_x_ 2 Tier ___ 3 Tier ___ 4 Tier	___ Fixed $ Amount ___ % of Premium	___ Other - please explain

Class Names:			
A001 - All Actives A002 - Hourly A003 - Salaried	A004 - Management A005 - Non-Management A006 - Union	A007 - Non-Union A008 - Full-Time A009 - Part-Time	R001 - Retired Non-Medicare Eligible R002 - Retired Medicare Eligible

Class Name	Plan Offering	Monthly Tier Contribution		HSA Annual Contribution (if applicable)
		Single	Family	
	Copay 1			n/a
	Copay 2			n/a
	Copay 3			n/a
	Hybrid 2			n/a
	Hybrid 3			n/a
	HSA 1			
	HSA 2			
	HSA 3			

Class Name	Plan Offering	Monthly Tier Contribution		HSA Annual Contribution (if applicable)
		Single	Family	
	Copay 1			n/a
	Copay 2			n/a
	Copay 3			n/a
	Hybrid 2			n/a
	Hybrid 3			n/a
	HSA 1			
	HSA 2			
	HSA 3			

Class Name	Plan Offering	Monthly Tier Contribution		HSA Annual Contribution (if applicable)
		Single	Family	
	Copay 1			n/a
	Copay 2			n/a
	Copay 3			n/a
	Hybrid 2			n/a
	Hybrid 3			n/a
	HSA 1			
	HSA 2			
	HSA 3			

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 of Member Firm Administrator *Date*

X _____

Signature of CTA Plan Administrator *Date*