



Bright Choices® Benefits Exchange™

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: Your first initial + last initial + last 4 of Social Security Number (SSN)

Password: 4-digit month and day of your date of birth plus the first 5 digits of your SSN

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

Personal Information

Employer:

Enrollment Type:

- Open Enrollment
 New Hire
 Status Change

Benefits Start Date:

Your Social Security Number:

Sex: Male Female Date of Birth: ___/___/___

Date of Hire: ___/___/___

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"/> Student		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student		

Please continue to other side.

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

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

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			

Long Term Disability Insurance	Short Term Disability Insurance	Accident Insurance	Critical Illness Insurance with Cancer Benefit																								
Yes___ No___ Monthly Income: _____	Yes___ No___ Desired Weekly Benefit: _____ Monthly Income: _____	Yes___ No___ <table style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;">Single</td> <td style="text-align: center;">Family</td> </tr> <tr> <td>Basic</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Enhanced</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Premier</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		Single	Family	Basic	_____	_____	Enhanced	_____	_____	Premier	_____	_____	Yes___ No___ Smoker? Yes___ No___ <table style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;">Single</td> <td style="text-align: center;">Family</td> </tr> <tr> <td>Basic</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Enhanced</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Premier</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		Single	Family	Basic	_____	_____	Enhanced	_____	_____	Premier	_____	_____
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	Single	Family																									
Basic	_____	_____																									
Enhanced	_____	_____																									
Premier	_____	_____																									

Employee Life & AD&D Insurance	Spouse Life & AD&D Insurance*	Child Life & AD&D Insurance*
Yes___ No___ Amount: _____ (\$50,000 to \$300,000)	Yes___ No___ Amount**: _____ (\$10,000 to \$100,000)	Yes___ No___ Amount: \$1,000 ___ \$2,000 ___ \$5,000 ___ \$3,000 ___ \$10,000 ___

*Employee must first elect self-coverage. **Must be less than 50% of employee coverage.

I certify that the personal information listed above is true, and that the indicated selections are my true final selections for benefits for 2012.

X _____
Signature Date _____

Please send completed forms to: Liazon, Attn: Chautauqua, 737 Main Street, Suite 200, Buffalo, NY 14203
 Or Fax to: 888-810-1059, Attn: Chautauqua