LOWER PRICES. SERIOUS SUPPORT.

2010 Personal Enrollment Form

Please fax completed forms to:
888-810-1059 Attn: Baron Payroll

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.
	☐ Spouse ☐ Male ☐ Domestic Partner ☐ Female		
	☐ Son ☐ Daughter		
	☐ Son ☐ Daughter		
	☐ Son ☐ Daughter		
	☐ Son ☐ Daughter		

Please continue to other side.

Questions? Contact Larry Kagan at Baron Payroll 631.266.2500 or larry@baronpayroll.com.
You may also contact 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.

	Oxford EPO	Oxford HSA Excl.	Oxford HMO	Emblem EPO	Emblem EPO InBal 1	Emblem EPO InBal 2	Emblem EPO w/HSA	Empire HMO	Empire PPO w/ HSA
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 you want.

Single	
Single + Spouse	
Single + Child(ren)	
Family	

Long Term Disability Insurance

Yes___ No___

Monthly Income:

____

Short Term Disability Insurance

Yes___ No___

Desired Weekly Benefit:

____

Accident Insurance

Yes___ No___

Basic___
Enhanced___
Premier___

Critical Illness Insurance with Cancer Benefit

Yes___ No___

Basic___
Enhanced___
Premier___

Employee Life & AD&D Insurance

Yes___ No___

Amount: _______________
($25,000 to $300,000;
Up to $50,000 Guaranteed Issue)

Spouse Life & AD&D Insurance*

Yes___ No___

Amount**: $10,000 ___
$20,000 ___
$30,000 ___

Child Life & AD&D Insurance*

Yes___ No___

Amount: $1,000 ___
$2,000 ___ $5,000 ___
$4,000 ___ $10,000 ___

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

Long Term Care

Yes___ No___

Starter___
Protection___
Superior Protection___

Tele-Medicine

Yes___ No___

Health Discount

Yes___ No___

Health and Wellness

Yes___ No___

Healthy Start___
Healthy Coach___
Healthy Directions___

Pet Insurance

Yes___ No___

Standard___
Superior___
Avian/Exotic___

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

X ____

Signature Date