



# Bright Choices<sup>®</sup> Benefits Exchange<sup>™</sup> — 2012

## 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: tonawanda

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: <input type="text"/>  Enrollment Type: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change  Benefits Start Date: <input type="text"/>	Your Social Security Number: <input type="text"/> Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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.**

## 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	_____	_____
	Single	Family																									
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Employee Life & AD&D Insurance	Spouse Life & AD&D Insurance*	Child Life & AD&D Insurance*
Yes___ No___  Amount: _____ (\$25,000 to \$300,000; Up to \$100,000 Guaranteed Issue)	Yes___ No___  Amount**: \$10,000 ___ \$20,000 ___ \$30,000 ___	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 2011.**

X \_\_\_\_\_  
Signature Date \_\_\_\_\_

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