



Bright Choices Group Enrollment Form 2009

This booklet provides the instructions and forms needed to enroll your company, with two or more benefit-eligible employees, in the Bright Choices program.

Group Enrollment Checklist

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

Liazon
737 Main Street, Suite 200
Buffalo, NY 14203
FAX 888-810-1059
- Use the Benefits Funding Worksheet on page 3 of this form to indicate the amount of your employees' benefits you are funding for 2009

Tell Us About Yourself

Your Name		Date:
Your Title/Position:		
Phone #	Email (required):	

Questions? Call 678-906-7753

You may also contact the Liazon Consumer Advocacy Team at 1-866-LIAZON-1

Tell Us About Your Business

Business Name

Business Address Street

City

State

Zip Code

Type of Business

Name of Business Owners/Partners

Key Contact Person Name

Phone

Fax

Email

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

Benefits Eligibility

What is the Benefits Eligibility Policy for your Company?

Eligible employees include all those working at least: 20 hrs 30 hrs 40 hrs Other: _____

Waiting period for all new/rehires is 1st of the month following: 30 days 60 90 Other: _____

How Many Eligible Employees Do you Have?

A) Total number of **ALL** active employees + owners +partners _____x

B) Total number of eligible **retirees**: _____x

C) Total number of **COBRA participants**: _____x

D) Total active employees not eligible _____x

E) Total **ELIGIBLES** (E = A+B+C-D): _____x

F) Eligibles declining due to a valid **waiver**: _____x

G) **NET ELIGIBLES** (G = E - F) _____x

*Note: All individuals who waive insurance must submit a waiver form. Group participation must be at least 50%

Please list all ELIGIBLE employees/owners/partners not listed on your tax documentation.

*All individuals listed must be working at least 20 hrs/wk

Name	Status	Social Security Number
	<input type="checkbox"/> New Hire <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	
	<input type="checkbox"/> New Hire <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	
	<input type="checkbox"/> New Hire <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	
	<input type="checkbox"/> New Hire <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	

If you need more space, please attach a separate sheet

Benefits Funding Worksheet

Through Liazon's award-winning *Bright Choices* portal, **Sandy Springs/Perimeter Chamber of Commerce** gives your employees decision support tools to help them select the benefits that are right for them based on cost and coverage. The program relies on a defined contribution strategy using dollar-amount allocations for funding employees' benefits. You can use this worksheet to determine how much money you will provide to your employees for their benefits for 2009.

- I am a single employee/sole proprietor company.** You can stop here, because you do not need to define benefits contributions for your employees.
- I have employees.** If you have employees besides yourself who receive benefits through your company, please provide the following information:

There are two alternatives for contributing to your employees' benefits. You can provide a single monthly contribution to cover all benefits. Or you can make separate contributions by type of insurance.

Please select to approach you wish to use and provide the appropriate contributions.

- The company will allocate a specific monthly amount *per employee* for ALL benefits:**

	Monthly Contribution
Single	\$ _____
Family	\$ _____

OR

- We will allocate specific monthly amounts per employee for SELECTED benefit (fill in all that apply):**

	Monthly Contribution			
	Medical	Dental	Vision	Other _____
Single	\$ _____	\$ _____	\$ _____	_____
Family	\$ _____	\$ _____	\$ _____	_____

How will life insurance and disability insurance be paid

Monthly Contribution	
Life Insurance	Disability Insurance
Employer Paid ___Yes ___No	Employer Paid ___Yes ___No

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

3 Signature
Date

