

Bright Choices® Benefits Exchange™

Group Enrollment Form

Group Enrollment Checklist:

- Complete all parts of this Group Enrollment Form
- 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 ____ 1065-K1 ____ Schedule C ____ Other: _____
- Include a business check with the 1st months premium (sole proprietors may send in one personal check if business check is not available)
- Attach Signed Rate Sheet(s) for plan(s) selected
- Use the Benefits Funding Worksheet on page 3 of this form to indicate the amount of your employees' benefits you are funding
**Please note, NYS mandates a minimum employer contribution of 50% of any single plan; if you contribute 100%, no waivers will be accepted, all eligible employees will be required to participate.
- Liazon Fee Schedule: Late Fee (\$100) if payment not received by the 20th
 Bounced check (\$25)
 Paper Invoices (\$2/invoice) if valid email is not provided below
- 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
 Or E-mail to myteammidwest@liazon.com

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 Code:
Business Mailing Address (if different):		
City:	State:	Zip Code:
Type of business:	SIC:	EIN/TIN#:
Name(s) of Business Owner(s)/Partner(s):		
Key Contact Person:		
Phone:	E-mail: <small>(Please print clearly, invoices will be emailed to this address)</small>	

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

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 _____		
Is your health plan governed by ERISA? Yes ___ No ___ If yes, ERISA plan month: _____		

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:

	Actual Date of Hire	FONM following: Date of Hire	FONM following: 30 days	FONM following: 60 days	FONM following: 90 days	FONAM following: Other
- NEW HIRES.....	_____	_____	_____	_____	_____	_____
- RE-HIRE.....	_____	_____	_____	_____	_____	_____
- PART-TIME EE'S WHO BECOME FULL-TIME.....	_____	_____	_____	_____	_____	_____

(*FONM = First of Next Month)

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 (G = E-F): _____
- 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: <input checked="" type="checkbox"/> 2 Tier <input type="checkbox"/> 3 Tier <input type="checkbox"/> 4 Tier	Premium Contribution Type: <input type="checkbox"/> Fixed \$ Amount <input type="checkbox"/> % of Premium	<input type="checkbox"/> Other - please explain
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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
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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 have read and agree to the fee schedule and 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