



Bright Choices® Benefits Exchange® — 2012

Group Enrollment Form

Group Enrollment Checklist:

Complete all parts of this Group Enrollment form

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

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 ____ 1020C ____ 1065-K1 ____ 1120S-K1 ____ Schedule C ____ Other: _____

Use the Benefits Funding Worksheet on page 3 of this form to indicate the amount of your employees' benefits you are funding

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:

Business Mailing Address (if different):

City: State: Zip:

Type of Business: SIC Code: EIN/TIN#:

Name(s) of Business Owner(s)/Partner(s):

Key Contact Person:

Phone: E-Mail:

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

(continued from page 1)

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 ___		

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:	
- All new hires is 1st of the month following:	Date of Hire ___ 30 days ___ 60 days ___ 90 days ___ Other: ___
- All rehires is 1st of the month following:	Date of Hire ___ 30 days ___ 60 days ___ 90 days ___ Other: ___
- Part-time ee's who become full-time is 1st of the month following:	Date of Hire ___ 30 days ___ 60 days ___ 90 days ___ Other: ___
How many eligible employees do you have?	
A) Total number of ALL active employees, owners, and partners at all locations: _____	<p>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.</p> <p>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.</p> <p>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.</p>
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 (I = E - F - G - H): _____	
J) Eligible employees enrolling in group enrolling (excluding retirees) _____	
K) Total Group Participation** (K = J / I): _____	
<p>*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</p>	

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 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