

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	Copay 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="width: 100%; border-collapse: collapse;"> <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="width: 100%; border-collapse: collapse;"> <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	_____	_____
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Employee Life & AD&D Insurance	Spouse Life & AD&D Insurance*	Child Life & AD&D Insurance*
Yes___ No___ Amount: _____ (\$50,000 to \$300,000)	Yes___ No___ Amount**: _____ (\$10,000 to \$100,000)	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 2012.

X _____
Signature Date _____

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