



Group Enrollment Form

Group Enrollment Checklist:

Complete all parts of this Group Enrollment form

Review, sign and return this form to:
Liazon
Attn: Kim Giesing
737 Main Street, Suite 200
Buffalo, NY 14203

Or Fax to: 888-810-1059, Attn: Kim Giesing

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 ____ 1120 ____ 1065-K1 ____ 1120S ____ 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 for the upcoming year

Tell Us About Yourself

Name:

Date:

Title/Position:

Phone:

E-Mail:

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

Benefits Funding Worksheet

Through Liazon's award-winning Bright Choices® portal, we're giving 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 the upcoming year.

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 the 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

The company will allocate specific monthly amounts *per employee* for SELECTED benefits:

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

Which, if any, of the following benefits will be employer paid?

Employee Life and AD&D	Long Term Disability	Short Term Disability	Accident	Critical Illness & Cancer Benefit
Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___
Long Term Care	Tele-Medicine	Health Discount	Health and Wellness	Pet Insurance
Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___	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 _____
Signature Date