



Personal Enrollment Form

Alternative to using online portal

The primary method for benefits enrollment is the Bright Choices portal.

Go to: <http://www.myliazon.com>

Group Identifier: westseneca

Username: First and last initials and the last 4 digits of your Social Security Number (no dashes or spaces)

Password: 4-digit month and day of your date of birth plus the first 5 digits of your Social Security Number

This alternative paper form may be completed by employees who do not have online access.

Please send completed forms to: Liazon, Attn: Kim Giesing, 737 Main Street, Suite 200, Buffalo, NY 14203

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

Personal Information	
Employer: <input type="text"/>	Your Social Security Number: <input type="text"/>
Enrollment Type: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Status Change	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: ___/___/___ Date of Hire: ___/___/___
	Last Name: _____ First Name: _____
Benefits Start Date: <input type="text"/>	Street: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ E-Mail: _____

Dependents (attach a separate sheet of paper for additional dependents):

First and Last Name	Relationship	Date of Birth	Social Security No.
	<input type="checkbox"/> Spouse <input type="checkbox"/> Male <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Female		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		

Please continue to other side.

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

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#: _____ Part A/B: ____ Effective Date: ____
 If enrolling your spouse, is he/she on Medicare? No Yes ID#: _____ Part A/B: ____ Effective Date: ____
 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" below to choose a plan and coverage level *or check here to waive:* ____

	Co-Pay 1	Co-Pay 2	Hybrid 1	Hybrid 2	Hybrid 3	HSA 1	HSA 2	HSA 3
Single								
Family								

Dental Insurance

Place an "X" below to choose a plan and coverage level *or check here to waive:* ____

	Value	Basic	Enhanced
Single			
Single + Spouse			
Single + Child(ren)			
Family			

Vision Insurance

Place an "X" below to choose a plan and coverage level *or check here to waive:* ____

	Plan A	Plan B	Plan C
Single			
Family			

Long Term Disability Insurance

Yes___ No___

Monthly Income: _____

Short Term Disability Insurance

Yes___ No___

Monthly Income: _____

Desired Benefit/Week: _____

Accident Insurance

Single___ Family___ No___

Basic___
Enhanced___
Premier___

Critical Illness Insurance with Cancer Benefit

Single___ Family___ No___

Basic___	Smoker?
Enhanced___	Yes___
Premier___	No___

Employee Life & AD&D Insurance

Yes___ No___

Amount: _____
(\$25,000 to \$300,000; Up to \$100,000 Guaranteed Issue)

Spouse Life & AD&D Insurance*

Yes___ No___

Amount**: \$10,000 ___
\$20,000 ___
\$30,000 ___

Child Life & AD&D Insurance*

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.

Long Term Care

Yes___ No___

Starter___
Protection___
Superior Protection___

Tele-Medicine

Yes___ No___

Health Discount

Yes___ No___

Health and Wellness

Yes___ No___

Healthy Start___
Healthy Coach___
Healthy Directions___

Pet Insurance

Yes___ No___

Standard___
Superior___
Avian/Exotic___

I certify that the personal information listed above is true, and that the indicated selections are my true final selections for benefits for the upcoming year.

X _____
Signature Date