



# Bright Choices® Exchange

## 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: **GCC**

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 first 5 digits of your social security number (i.e. MMDDSSSSS)

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

Please send completed forms to: Bouchey & Clarke Benefits, Inc., P.O. Box 1616, Troy, NY 12181 or email to [kdepew@bouchey.com](mailto:kdepew@bouchey.com) or fax to 518-874-5002.

### Personal Information

Employer:

Enrollment Type:

Open Enrollment      Tax ID#: \_\_\_\_\_  
 New Hire  
 Status Change (Describe: \_\_\_\_\_)

Benefits Start Date:

 /  / 

#### Your Social Security Number:

Sex:  Male  Female      Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Date of Hire: \_\_\_/\_\_\_/\_\_\_

Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ First Name: \_\_\_\_\_

Street:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

**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"/> Smoker <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Female		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student <input type="checkbox"/> Smoker		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student <input type="checkbox"/> Smoker		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student <input type="checkbox"/> Smoker		
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Student <input type="checkbox"/> Smoker		

Please continue to other side.

**Questions? Call Bouchey & Clarke Benefits, Inc. at 518-272-9866 or email [kdepew@bouchey.com](mailto:kdepew@bouchey.com) or 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: \_\_\_\_

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Single								
Two-Person								
Family								

**\*For HMO plan only:** you and each dependent MUST select a Primary Care Physician (PCP). Females may also choose one OB/GYN.

Name	Physician Name: Last, First, M.I.	Primary or OB/GYN	Office Location	Physician Number	Current Patient?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

### Health Savings Account (HSA)

To contribute to an HSA, you must enroll in a qualified HSA plan above.

**I want to open an HSA.** You will need to provide a KeyBank Application and Adoption form to open your account.

### 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			

**I certify that the personal information listed above is true, and that the indicated selections are my true final selections for benefits for 2011-2012.**

X \_\_\_\_\_  
 Signature Date