Ulster County Regional Chamber of Commerce

Bright Choices® Benefits Exchange™

SMALL GROUP (CDPHP) Personal Enrollment Form

Alternative to using online portal

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

Go to: exchange.liazon.com
Username: UCC + Your first initial + last initial + last 4 of Social Security Number (SSN)
Password: Full Social Security Number (no spaces or dashes)

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

Personal Information

Employer:

Enrollment Type:

- ☐ Open Enrollment
- ☐ New Hire
- ☐ Status Change

Benefits Start Date: _____ / _____ / _____

Salary: (*1) $

Your Social Security Number:

Sex: ☐ Male ☐ Female

Date of Birth: ___ / ___ / _____

Date of Hire: ___ / ___ / _____

Last Name: First Name:

Street:

City: State: Zip:

County: Phone:

E-Mail:

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

First and Last Name	Relationship	Date of Birth	Social Security No.
	☐ Spouse ☐ Male ☐ Domestic Partner ☐ Female		
	☐ M ☐ F ☐ Full-Time Student		
	☐ M ☐ F ☐ Full-Time Student		
	☐ M ☐ F ☐ Full-Time Student		
	☐ M ☐ F ☐ Full-Time Student		

(*2)

Please continue to other side.

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

(*) See corresponding footnote on page 3

Benefits Information and Enrollment

All Benefits Selections Left Blank Will Be Treated As Waived Coverage.

Are you on Medicare (*3)? No ☐ Yes ☐ If Yes, please include your ID#: _____ Part A Eff. Date: _____ Part B Eff. Date: _____

If enrolling your spouse, is he/she on Medicare? No ☐ Yes ☐ ID#: _____ Part A Eff. Date: _____ Part B Eff. Date: _____

Have you been enrolled in another insurance policy in the last 63 days (*4)? ☐ 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:

CDPHP Small Group Medical Insurance

Place an "X" below to choose a plan and coverage level you want.

	Platinum EPO 100	Gold EPO 221	Gold EPO 222	Silver EPO 320	Silver EPO 322	Bronze EPO 400	Bronze EPO 421	Bronze EPO 422
Single								
Single + Spouse								
Single + Child(ren)								
Family								

You and each dependent must select a Primary Care Physician (PCP) and OB/GYN for females.

Name	Physician Name: Last, First, M.I.	Primary or OB/GYN	Office Location	Physician Number	Current Patient?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Dental Insurance

Place an "X" below to choose a plan and coverage level you want.

	Value (LOW)	Basic (MID)	Enhanced (HIGH)
Single			
Single + Spouse			
Single + Child(ren)			
Family			

Vision Insurance

Place an "X" below to choose a plan and coverage level you want.

	Option 1	Option 2	Option 3	Option 4
Single				
Single + Spouse				
Single + Child(ren)				
Family				

Employee Life & AD&D Insurance	Spouse Life & AD&D Insurance*	Child Life & AD&D Insurance*
Yes___ No___ Amount: _____ ($25,000 to $300,000; Up to $100,000 Guaranteed Issue) (*5)	Yes___ No___ Amount: _____ ($10,000 to $100,000)(*8) (*6)	Yes___ No___ Amount: $10,000 ___ (*7)

*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.

X _____

Signature Date

Please send completed forms to: Liazon, Attn: Ulster, 199 Scott St., 8th Fl., Buffalo, NY 14204 Or Fax to: 888-810-1059, Attn: Ulster

(*) See corresponding footnote on page 3

Footnotes

1. **Salary Requirement**
   Multiple benefits offered are based on your income level, so in order for us to provide you with accurate and timely enrollments, we need your base salary listed. This information will not be shared with anyone other than the carriers that need the information.

2. **Full-Time Student Definition**
   Multiple benefits offered have a 19/25 dependent rider. If your dependent is over the age of 19, they must be a full time student to qualify as a dependent. Full time student is at least 12 credit hours per semester. Please note – this is not applicable for Medical – all dependent riders for Medical are 26/26 and no student status is required.

3. **Medicare**
   If you are Medicare eligible, it is imperative for you to note your effective dates for both Parts A & B for claims processing.

4. **Prior Coverage Information**
   If you have had coverage within the last 63 days, it is imperative that you complete this section, otherwise claims could be denied due to the Pre-Existing Condition clause. A Pre-Existing Condition is a condition/illness in which you have sought medical advice/treatment for during a period where you were not covered by a creditable medical insurance plan for longer than 63 days.

5. **Voluntary Life and AD&D Insurance**
   This is a salary-related benefit. Statement of Health may be required if amount elected is over guaranteed issue.

6. **Spouse Life and AD&D Insurance**
   Not available unless Employee elects Voluntary Life and AD&D. Must be less than 50% of Employee Elected coverage. Statement of Health may be required if amount elected is over guaranteed issue.

7. **Child Life and AD&D Insurance**
   Not available unless Employee elects Voluntary Life and AD&D.