Ulster County Regional Chamber of Commerce

Bright Choices® Benefits Exchange™

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: $

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		

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 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? ☐ 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

Please circle the CARRIER, PLAN LEVEL, COVERAGE TIER and write in the PLAN RATE & PLAN NAME

PLAN LEVEL SELECTION	PLAN LEVEL SELECTION	COVERAGE TIER SELECTION	PLAN RATE	PLAN NAME
CDPHP - Small Group	Platinum	Single		
MVP - Small Group	Gold	Single + Spouse		
MVP - Individual	Silver	Single + Child(ren)		
	Bronze	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				

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 Street, 8th Floor, Buffalo, NY 14204 Or Fax to: 888-810-1059, Attn: Ulster