



Bright Choices Personal Enrollment Form (Alternative) 2009

The primary method for benefits enrollment in 2009 is the Bright Choices portal. Go to: <http://www.myliazon.com>

Group Identifier: Alden

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

Password: Your full 9-digit Social Security Number (no dashes or spaces).

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:

Your Social Security #	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____ Date of Hire ____/____/____
Last Name		First
Street		
City	State	Zip
Phone #	Email	

Dependents:

First and Last Name	Relationship	Date of Birth	Social Security #
	<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		

Use a separate sheet of paper for additional dependents

Please continue to the next page to complete your enrollment



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#: _____
 If enrolling your spouse, is he/she on Medicare? No Yes ID#: _____
 Have you been enrolled in another insurance policy in the last 63 days? No Yes
 If Yes, please provide the following info 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 info about the covered person(s):

Name (if everyone, write "All"):	Insurance ID #:
Insurance Company Name:	Beginning Date of Prior Coverage:

Medical Insurance

Place an "X" in the box for the plan and coverage level you want

	Copay	Hybrid	HSA #1 (\$1,300/\$2,600)	HSA #2 (\$5,500/\$11,000)
Single				
Family				

I Waive Medical Coverage if you're covered under someone else's medical insurance, you must submit a health waiver form

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 Waive Dental Coverage

Health Savings Account (HSA)

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

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

Vision Insurance

Place an "X" in the box for the plan and coverage level you want

	Plan A	Plan B	Plan C
Single			
Family			

I Waive Vision Coverage

Accident Insurance

Elect Coverage? No Yes

Which Plan:

Basic Enhanced Premier

Critical Illness Insurance

Elect Coverage? No Yes

Which Plan:

Basic Enhanced Premier

Employee Life Insurance Selection

Place an "X" under your desired amount: of life insurance

NONE	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$225,000	\$250,000

You must complete a MetLife Statement of Health form for these levels

Spouse Life Insurance

Child(ren) Life Insurance **

Long-term Disability Insurance

\$10,000*	\$20,000*	\$30,000*	\$1,000	\$2,000	\$4,000	\$5,000	\$10,000	Elect Coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes
								Salary \$_____/yr Title_____

* Must be less than 50% of employee coverage

**To elect this coverage, you must first elect self-coverage.

I certify that the personal information listed above is true, and that the indicated selections are my true final selections for benefits for 2009-2010.

Signature _____ Date _____