



Online Enrollment Guide

Welcome!

To begin your Benefit Enrollment [please click on the link below](#) to access SHSD benefit enrollment system.

<https://trustmark.benselect.com/Enroll/login.aspx?ReturnUrl=%2fenroll>

The screenshot shows the Trustmark login interface. On the left, there are two input fields. The first is labeled "Employee ID or SSN" and has a red arrow pointing to it. The second is labeled "PIN" and also has a red arrow pointing to it. To the right of the PIN field is a blue link that says "Need help?". Below the input fields is an orange "Log in" button. On the right side of the page, the Trustmark logo is displayed, followed by the text "Welcome!" and "You can enroll yourself in your employee benefits here." Below that, it says "Enrollers, use the [admin site](#) instead." At the bottom left, there is a disclaimer: "By entering your user ID and Personal Identification Number, you are agreeing to the terms of the [Consent to Enroll Electronically](#)." At the bottom right, there are links for "Security Info" and "Privacy Policy".

To log-in follow these steps:

- 1. Enter your Social Security Number**
- 2. PIN = The last four of your Social Security Number and the last two digits of your birth year (no spaces)**
- 3. Click LOGIN**

Welcome to Your Benefit Enrollment for Plan Year

At Spring Hill School District, we know that benefit requirements change. That's why we have an open enrollment period each year.

For most benefits, Open Enrollment is the only time of year you are allowed to make changes in your benefits. Unless you experience some qualifying life event, you will only be able to make benefit changes during the Open Enrollment period. During open enrollment, you should consider the benefits you have today and ask yourself if they will serve you and your loved ones well in the coming plan year.

Benefit enrollment is easy! Just follow these steps.

- First, review and contact HR to update personal information about you or your covered dependents.
- Review each of your benefit elections and make your choices.
- Sign the Enrollment Confirmation form to complete your enrollment.

Click *Next* to begin.

✓ Your Benefit Options

[Health](#)
[Health Care FSA](#)
[Dependent Care FSA](#)
[Dental](#)
[Vision](#)
[Basic Life & AD&D](#)
[Short-Term Disability](#)
[Trustmark Universal Life](#)
[Trustmark Accident Insurance](#)
[Allstate Benefits Critical Illness](#)
[Allstate Identity Protection](#)
[EAP Membership Plan](#)

Press *Next* to review personal information and begin enrollment.

Next

Click "Next" from the Welcome screen to start the enrollment process.

Be sure to read ALL of the information on each enrollment screen.

Your enrollment is not complete until you see **CONGRATULATIONS!**

Ensure that all of your personal information is accurate, then click "Next". You should be able to update your address. All of the other fields (name, DOB, SSN) are locked and you will need to contact HR to update.

Personal Information

Please review your personal information to ensure it is correct and complete. Please correct any errors and click the *Next* button when you are finished.

Optional items are in *italics*.

Personal Info

Name:	<input type="text" value="Crystal"/>	<input type="text"/>	<input type="text" value="Tester-test"/>	<input type="text"/>
	<small>First</small>	<small>MI</small>	<small>Last</small>	<small>Suffix</small>
Date of Birth:	<input type="text" value="05/27/1954"/>			
SSN:	<input type="text" value="***-**-2222"/>			
Gender:	<input type="radio"/> Male <input checked="" type="radio"/> Female			

Contact Info

Address:	<input type="text" value="USA"/>		
	<small>Country</small>		
	<input type="text" value="5 W Susana Blvd"/>		
	<small>Street</small>		
	<input type="text"/>		
	<small>Street (cont.)</small>		
	<input type="text" value="Topeka"/>	<input type="text" value="KS"/>	<input type="text" value="66612"/>
	<small>City</small>	<small>State</small>	<small>Zip</small>
Home Phone:	<input type="text"/>		
Work Phone:	<input type="text"/>		
Mobile Phone:	<input type="text"/>		
E-MAIL:	<input type="text" value="Crystal.Tester-test@demo-me.com"/>		
Personal EMail:	<input type="text"/>		

Beck



Previous dependent information will be reflected on the Dependents screen. Click the plus sign to add a new dependent or click "Next" to continue to enroll in your benefits.

Home You & Your Family My Benefits Sign & Submit

Dependents

Click Add ("Plus" icon at top right of table) to add your spouse or dependent children. Dependent children may only be covered in a plan if they meet the necessary requirements defined by the plan. Click the Next button when you are finished.

Name	SSN	DOB	Sex	Relation	Uploads	
Jesse Tester-test	***-**-2645	9/12/1949	M	Spouse	0	+ ✕

Add a Dependent

If your dependent is not listed above or you would like to add an additional dependent, simply click the Add Dependent button below.

+ Add Dependent

Back Next

The next screen will show all of the benefits you are currently enrolled in. If you wish to make changes to any of the benefits you are currently enrolled in, click the "Review" button on each coverage. If you do not want to make any changes, click Next at the bottom of the page and the system will require you to go in and enroll or waive any coverages you aren't currently enrolled in.

If you are not currently enrolled in any benefits, you will need to click review on each coverage to elect or waive coverage.

Spring Hill SCHOOL DISTRICT (42% Complete)

Home You & Your Family My Benefits Sign & Submit Back Next

Quick Enroll

Below is a list of your current benefit elections. For each of the benefit options below, your "Quick Enroll" option is shown. Click the Quick Enroll link to accept on each one, or click "Review" to review your other options.

Health Review

Enrollment Details

Product Name: BlueSelect Plus QHDHP with SpiraCare
Coverage Level: Employee Only

First Name	MI	Last Name	DOB	Sex	Relationship
Benjamin	D	Anderson	8/26/1998	M	Employee

You have completed enrollment in this plan. Your cost per pay period will be \$0.00

Health Savings Account Review

Enrollment Details

You have elected an annual contribution: \$1,886.52

You have completed enrollment in this plan. Your cost per pay period will be \$73.18

My Benefits

- Health \$0.00
- Health Savings Account \$73.18
- Health Care FSA \$0.00
- Dependent Care FSA \$0.00
- Dental \$0.00
- Vision \$7.04
- Basic Life & AD&D \$0.00
- Short-Term Disability \$0.00
- Trustmark Universal Life \$0.00
- Trustmark Accident Insurance \$0.00
- Allstate Benefits Critical Illness \$0.00
- Allstate Identity Protection \$0.00

Employer Cost	\$832.34
Pre-tax cost	\$80.22
Post-tax cost	\$0.00
Total Cost	\$80²²
Total Per Pay Period	

Health

Listed below are the options and coverage choices available to you.

- To enroll or continue your current coverage, click the option that represents your election.
- You can edit which dependents will be covered by using the pencil icon next to the list of Covered People when available.
- When you are finished, click on the **Enroll** or Next button to continue.

Please Note: Spring Hill will contribute \$84.03 per month for all Certified/Classified Category 1 employees if you enroll in the BlueSelect Plus QHDHP with SpiraCare plan and you elect to enroll in the health savings account.

View Existing Coverage

Benefit Amount: N/A Cost: \$0.00/Monthly Pre-Tax

First Name	MI	Last Name	DOB	Sex	Relationship
	D			M	Employee

BLUESELECT PLUS PPO	PREFERRED-CARE BLUE PPO	BLUE SAVER QHDHP
BlueSelect Plus PPO	Preferred - Care Blue PPO	Blue Save QHDHP
Your Cost: Per Pay Period <input checked="" type="radio"/> Employee Only: \$0.00 <input type="radio"/> Employee + Spouse: \$887.77 <input type="radio"/> Employee + Children: \$815.37 <input type="radio"/> Employee+Family: \$1,248.02	Your Cost: Per Pay Period <input checked="" type="radio"/> Employee Only: \$106.29 <input type="radio"/> Employee + Spouse: \$1,093.38 <input type="radio"/> Employee + Children: \$1,011.66 <input type="radio"/> Employee+Family: \$1,500.38	Your Cost: Per Pay Period <input checked="" type="radio"/> Employee Only: \$0.00 <input type="radio"/> Employee + Spouse: \$836.92 <input type="radio"/> Employee + Children: \$767.83 <input type="radio"/> Employee+Family: \$1,193.66
Covered People:	Covered People:	Covered People:
Enroll	Enroll	Enroll

Current

BLUESELECT PLUS SPIRACAR	BLUESELECT PLUS QHDHP W/	BLUESELECT PLUS EPO PLAN
BlueSelect Plus Spira	BlueSelect Plus QHDHP with SpiraCare	BlueSelect Plus EPO

My Benefits

Health	\$0.00
Health Savings Account	\$73.18
Health Care FSA	\$0.00
Dependent Care FSA	\$0.00
Dental	\$0.00
Vision	\$7.04
Basic Life & AD&D	\$0.00
Short-Term Disability	\$0.00
Trustmark Universal Life	\$0.00
Trustmark Accident Insurance	\$0.00
Albstate Benefits Critical Illness	\$0.00
Albstate Identity Protection	\$0.00

Employer Cost	\$119.34
Pre-tax cost	\$80.22
Post-tax cost	\$0.00
Total Cost	\$80²²
Total Per Pay Period	

Find the Health plan you wish to elect. Select the coverage option, then click "Enroll".

After each benefit screen, you will see a screen that will ask you to confirm the plan you enrolled in, or confirm that you are waiving coverage. Click Next to move to the next benefit.

If you choose to contribute to your Health Care FSA, you can select an amount per pay period or a total amount. After inputting an amount, click the "Calculate" button. Then, click the "I wish to apply for coverage" radio button and click "Next" to enroll.

If you prefer not to contribute, click the "I wish to DECLINE this coverage" button and click "Next" to waive.

The image shows a web form for enrolling in a Health Care FSA. At the top left is the Spring Hill School District logo with a progress bar indicating 31% completion. The navigation bar includes 'Home', 'You & Your Family', 'My Benefits', and 'Sign & Submit'. The main heading is 'Health Care FSA'. Under 'Your FSA Election', there is explanatory text and a list of instructions. The form contains several input fields: 'Maximum Annual Contribution' (pre-filled with \$3,050.00), 'Amount per pay period' (input field with \$41.66), 'Number of periods' (pre-filled with 12), 'Lump Sum' (input field with \$0.00), and 'Total Amount' (input field with \$499.92). A 'Calculate' button is located below these fields. To the right, a 'My Benefits' sidebar lists various options with their costs, including Health Savings Account, Health Care FSA, Dental, Vision, and Life Insurance. At the bottom, there are two radio buttons: 'I wish to apply for this coverage' and 'I wish to DECLINE this coverage'. Navigation buttons for 'Back' and 'Next' are also present.

Maximum Annual Contribution: \$3,050.00

Amount per pay period:

Number of periods: 12

Lump Sum:

Total Amount:

Calculate

I wish to apply for this coverage

I wish to DECLINE this coverage

My Benefits

<input type="radio"/> Health	\$0.00
<input checked="" type="radio"/> Health Savings Account	\$0.00
<input checked="" type="radio"/> Health Care FSA	\$0.00
<input type="radio"/> Dependent Care FSA	\$0.00
<input checked="" type="radio"/> Dental	\$0.00
<input checked="" type="radio"/> Vision	\$7.04
<input checked="" type="radio"/> Basic Life & AD&D	\$0.00
<input type="radio"/> Short-Term Disability	\$0.00
<input type="radio"/> Trustmark Universal Life	\$0.00
<input type="radio"/> Trustmark Accident Insurance	\$0.00
<input type="radio"/> Allstate Benefits Critical Illness	\$0.00
<input type="radio"/> Allstate Identity Protection	\$0.00

Employer Cost: \$35.31
Pre-tax cost: \$7.04
Post-tax cost: \$0.00

Total Cost \$7⁰⁴
Total Per Pay Period

Back **Next**



Dependent Care FSA

Your FSA Election

A flexible spending account allows you to set aside pre-tax money to pay for expenses not covered by your insurance. The minimum and maximum contribution amounts for the next plan year are shown below.

- If you would like to enroll in the Dependent Care FSA plan, enter the amount you would like to contribute for plan year. Then click on the button next to the text which reads "I wish to apply for this coverage".
- If you do not want to enroll in the Dependent Care FSA plan, click on the button next to the text which reads "I wish to DECLINE this coverage".
- When you are finished, click on the "NEXT"

Maximum Annual Contribution:	\$5,000.00
Amount per pay period:	<input type="text" value="\$0.00"/>
Number of periods:	12
Total Amount:	<input type="text" value="\$0.00"/>

Calculate

- I wish to apply for this coverage
- I wish to DECLINE this coverage

My Benefits	
<input type="radio"/> Health	\$0.00
<input checked="" type="radio"/> Health Savings Account	\$0.00
<input type="radio"/> Health Care FSA	\$0.00
<input checked="" type="radio"/> Dependent Care FSA	\$0.00
<input checked="" type="radio"/> Dental	\$0.00
<input checked="" type="radio"/> Vision	\$7.04
<input checked="" type="radio"/> Basic Life & AD&D	\$0.00
<input type="radio"/> Short-Term Disability	\$0.00
<input type="radio"/> Trustmark Universal Life	\$0.00
<input type="radio"/> Trustmark Accident Insurance	\$0.00
<input type="radio"/> Allstate Benefits Critical Illness	\$0.00
<input type="radio"/> Allstate Identity Protection	\$0.00
Employer Cost	\$35.31
Pre-tax cost	\$7.04
Post-tax cost	\$0.00
Total Cost	\$7.04
Total Per Pay Period	

Back

Next

If you choose to contribute to your Dependent Care FSA, you can select an amount per pay period or a total amount. After inputting an amount, click the "Calculate" button. Then, click the "I wish to apply for coverage" radio button and click "Next" to enroll.

If you prefer not to contribute, click the "I wish to DECLINE this coverage" button and click "Next" to waive.

Dental

DELTA DENTAL OF KANSAS

Your Cost: Per Pay Period

Employee Only: \$0.00

Employee + Spouse: \$26.29

Employee + Children: \$33.75

Employee+Family: \$97.94

Covered People:

Jerry Test

Spouse Test

Enroll

DECLINE COVERAGE

You should only decline coverage if you are covered elsewhere. Declining coverage may require you to answer questions about your reasons for declining.

Your Cost: \$0.00

Decline

My Benefits

- Health \$0.00
- Health Savings Account \$0.00
- Health Care FSA \$50.00
- Dependent Care FSA \$0.00
- Dental \$0.00
- Surency Vision \$0.00
- Basic Life & AD&D \$0.00
- Short-Term Disability \$0.00
- Trustmark Universal Life \$0.00
- Trustmark Accident Insurance \$0.00
- Allstate Critical Illness \$0.00
- InfoArmor \$0.00

Employer Cost \$563.86

Pre-tax cost \$50.00

Post-tax cost \$0.00

Total Cost

\$50⁰⁰

Enroll in Dental coverage by selecting the coverage option of your choice and clicking “Enroll” to continue. You can waive coverage by clicking “Decline”.

Vision

VISION EYEMED

Your Cost: Per Pay Period

Employee Only: \$7.04

Employee + Spouse: \$14.76

Employee + Children: \$12.65

Employee+Family: \$23.67

Covered People:

Curtis B. Allen, Allen

Enroll

DECLINE COVERAGE

You should only decline coverage if you are covered elsewhere. Declining coverage may require you to answer questions about your reasons for declining.

Your Cost: \$0.00

Decline

My Benefits

- Health \$61.99
- Health Care FSA \$0.00
- Dependent Care FSA \$0.00
- Dental \$0.00
- Vision \$0.00
- Basic Life & AD&D \$0.00
- Short-Term Disability \$36.40
- Trustmark Universal Life \$0.00
- Trustmark Accident Insurance \$0.00
- Allstate Benefits Critical Illness \$0.00
- Allstate Identity Protection \$0.00
- EAP Membership Plan \$0.00

Employer Cost \$701.05

Pre-tax cost \$61.99

Post-tax cost \$36.40

Total Cost

\$98³⁹

Enroll in Vision coverage by selecting the coverage option of your choice and clicking “Enroll” to continue. You can waive coverage by clicking “Decline”.

Basic Life & AD&D

When finished reviewing please press *Next*.

Benefit Amount: **\$20,000**
Cost: **\$0.00**

[Back](#) [Next](#)

My Benefits	
<input checked="" type="checkbox"/> Health	\$0.00
<input checked="" type="checkbox"/> Health Savings Account	\$0.00
<input checked="" type="checkbox"/> Health Care FSA	\$50.00
<input checked="" type="checkbox"/> Dependent Care FSA	\$0.00
<input checked="" type="checkbox"/> Dental	\$26.29
<input checked="" type="checkbox"/> Surency Vision	\$0.00
<input checked="" type="checkbox"/> Basic Life & AD&D	\$0.00
<input type="checkbox"/> Short-Term Disability	\$0.00
<input type="checkbox"/> Trustmark Universal Life	\$0.00
<input type="checkbox"/> Trustmark Accident Insurance	\$0.00
<input type="checkbox"/> Allstate Critical Illness	\$0.00
<input type="checkbox"/> InfoArmor	\$0.00
Employer Cost \$597.37	
Pre-tax cost \$76.29	
Post-tax cost \$0.00	
Total Cost	\$76²⁹
Per Pay Period	

Click "Next" to automatically enroll in the employer provided Basic Life and AD&D plan

Basic Life & AD&D

Choose Beneficiaries

A beneficiary is a person, trust, or organization to whom benefits will be paid. A contingent beneficiary will receive benefits if your primary beneficiary is no longer living at the time of your death.

- Place a checkmark next to each desired primary and contingent beneficiary. The percentage allocations will automatically recalculate.
- Click Add if you do not see the desired person or trust in the list.
- You may change the percentages, as long as they add up to 100%.
- Clicking *All living children* will clear any children already selected.
- Beneficiaries may not be both primary and contingent at the same time.

Beneficiary	Relationship	Primary	Contingent	
Spouse Test	Spouse	<input checked="" type="checkbox"/> 100.00%	<input type="checkbox"/> 0.00%	
Child Test	Child	<input type="checkbox"/> 0.00%	<input checked="" type="checkbox"/> 100.00%	
All Living Children		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	
Estate		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	

[Back](#) [Next](#)

Select a primary beneficiary and a contingent beneficiary (optional) by checking the corresponding radio buttons. Click "Next" to continue.

Short-Term Disability

Spring Hill provides employees with the opportunity to purchase Short-Term Disability (STD) coverage through OneAmerica. This description provides a look at the three options available dependent upon which best fits your personal needs. Please refer to full plan description for greater detail.

The benefit amount for this plan is based on a percentage of your salary. Please select the desired percentage from the list below and indicate whether or not wish to have coverage before pressing Next.

OneAmerica Voluntary Short-Term Disability Plans			
Plan Options	Option 1	Option 2	Option 3
Accident Elimination	0 days	14 days	30 days
Sickness Elimination	7 days	14 days	30 days
Benefit Duration	26 weeks	24 weeks	22 weeks
Benefit Amount	Increments of \$50 up to 70% of covered weekly earnings		
Minimum Weekly Benefit	\$25		
Maximum Weekly Benefit	\$2,500		
Pre-Existing Condition	12/12		
Monthly Premium Rate per \$10 of Weekly Benefit	\$1.11	\$0.93	\$0.52

Benefit Levels: 0Acc/7Sick 14Acc/14Sick 30Acc/30Sick

Click Next to continue.

Benefit Amount :  \$600

Cost per pay period: \$31.20

- I wish to apply for this coverage
- I wish to DECLINE this coverage

Back

Next

To enroll in Short-Term Disability coverage, elect the plan option of your choice. Select the benefit amount by clicking the arrows or moving the slider. Then, click the "I wish to apply for coverage" radio button and click "Next" to enroll.

If you prefer not to enroll, click the "I wish to DECLINE this coverage" button and click "Next" to waive.

Trustmark Universal Life

 Watch: Universal Life Video

 You may apply for coverage for any of the individuals listed below. To view prices or apply, click the name of the person in the list below.

Name	Relationship	Sex	DOB	Riders
Jerry Test 	Employee	M	1/1/1957	
Spouse Test	Spouse	F	1/1/1950	
Child Test	Child	F	1/1/2016	

- I do wish to CONFIRM changes
- I wish to CANCEL changes made in this enrollment session.

[Back](#)

 [Next](#)

To enroll in Universal Life coverage, click on the person you wish to cover. If you do not want to make any changes, you can click “Next” to continue.

Trustmark Universal Life

Select the desired benefit amount or cost from the list below. If you wish you may enter a specific coverage amount or benefit amount. You may select any optional coverages (if offered) from the list below.

[Watch: Universal Life Video](#)

To apply, select *I wish to apply for this coverage*. If you do not wish to purchase this coverage, choose *I wish to DECLINE this coverage*. Press Next when you are finished. Your benefit will decrease at age 70.

Insurance for Jerry Test

Does anyone proposed for coverage smoke cigarettes or during the past 12 months has anyone proposed for coverage smoked cigarettes?

Cost per Pay Period	Benefit Amount
<input checked="" type="radio"/> \$15.89	5,000
<input type="radio"/> \$65.01	25,000
<input type="radio"/> \$126.40	50,000
<input type="radio"/> \$187.80	75,000
<input type="radio"/> \$249.19	100,000
<input type="radio"/> \$371.98	150,000
<input type="radio"/> \$494.78	200,000

Cost per Pay Period:

Benefit Amount:

My Benefits	
<input checked="" type="checkbox"/> Health	\$0.00
<input checked="" type="checkbox"/> Health Savings Account	\$0.00
<input checked="" type="checkbox"/> Health Care FSA	\$50.00
<input checked="" type="checkbox"/> Dependent Care FSA	\$0.00
<input checked="" type="checkbox"/> Dental	\$26.29
<input checked="" type="checkbox"/> Surrency Vision	\$0.00
<input checked="" type="checkbox"/> Basic Life & AD&D	\$0.00
<input checked="" type="checkbox"/> Short-Term Disability	\$18.20
<input checked="" type="checkbox"/> Trustmark Universal Life	\$0.00
<input type="checkbox"/> Trustmark Accident Insurance	\$0.00
<input type="checkbox"/> Allstate Critical Illness	\$0.00
<input type="checkbox"/> InfoArmor	\$0.00
<hr/>	
Employer Cost	\$599.17
Pre-tax cost	\$76.29
Post-tax cost	\$18.20
Total Cost	\$94⁴⁹
Per Pay Period	

Application riders

Base Policy	\$13.32
<input checked="" type="checkbox"/> Long Term Care (LTC) Monthly Living Benefit (year 0) is \$200	\$1.49
<input checked="" type="checkbox"/> Benefit Restoration (BRR)	\$1.08
<input checked="" type="checkbox"/> EZ Value (EZV) <input type="text" value="\$1 - 5 yrs"/>	
Total Premium: \$15.89	

I wish to apply for this coverage

I wish to DECLINE this coverage

To enroll in Universal Life coverage, choose the appropriate option from the drop down to indicate smoker/non-smoker status. Select the amount of coverage and click "Next" to enroll.

Trustmark Universal Life

Employment: Full-Time

Will this insurance replace, in whole or in part, any life, accident and sickness, long-term care insurance or annuity? YES NO

Back Next

Answer the questions when prompted, then click "Next" to continue.

Trustmark Accident Insurance

Accident insurance from Trustmark helps pay for the unexpected expenses that result from accidents. It pays benefits above and beyond what your health insurance plan pays.

[Watch: Accident Video](#)

To apply, select *I wish to apply for this coverage*. If you do not wish to purchase this coverage, choose *I wish to DECLINE this coverage*. Press Next when you are finished.

Coverage Employee Only Employee + Spouse Employee + Children Employee+Family

HospitalPlan Plan 4

Cost per Pay Period: **\$12.89**

My Benefits	
<input checked="" type="checkbox"/> Health	\$0.00
<input checked="" type="checkbox"/> Health Savings Account	\$0.00
<input checked="" type="checkbox"/> Health Care FSA	\$50.00
<input checked="" type="checkbox"/> Dependent Care FSA	\$0.00
<input checked="" type="checkbox"/> Dental	\$26.29
<input checked="" type="checkbox"/> Surency Vision	\$0.00
<input checked="" type="checkbox"/> Basic Life & AD&D	\$0.00
<input checked="" type="checkbox"/> Short-Term Disability	\$18.20
<input checked="" type="checkbox"/> Trustmark Universal Life	\$15.89
<input checked="" type="checkbox"/> Trustmark Accident Insurance	\$0.00
<input type="checkbox"/> Allstate Critical Illness	\$0.00
<input type="checkbox"/> InfoArmor	\$0.00
<hr/>	
Employer Cost	\$599.17
Pre-tax cost	\$76.29
Post-tax cost	\$34.09
Total Cost Per Pay Period	\$110³⁸

Application riders

Base Policy		\$10.90
<input checked="" type="checkbox"/> Health Screening Rider (HSR)	50	\$0.67
<input checked="" type="checkbox"/> Accidental Death Benefit (ADB)		\$1.32
Total Premium:		\$12.89

I wish to apply for this coverage I wish to DECLINE this coverage

Back Next

To enroll in Accident coverage, select the option to choose who will be covered. Then, choose the plan that you wish to elect. Continue by clicking "Next".

To decline the Accident coverage, click the "I wish to DECLINE this coverage" radio button, then click "Next".

Allstate Critical Illness

Listed below are the options and coverage choices available to you.

- To enroll or continue your current coverage, click on the option next to the cost which represents your election.
- When you are finished, click on the "NEXT" button to continue.

Please select the desired benefit level

Benefit Levels: No Tobacco Yes Tobacco

Employee Only	Employee + Spouse	Employee + Children	Employee+Family
<input checked="" type="radio"/> \$40.05	<input type="radio"/> \$60.69	<input type="radio"/> \$40.05	<input type="radio"/> \$60.69

Benefit Amount: \$10,000

- I wish to apply for this coverage
- I wish to DECLINE this coverage

My Benefits	
<input checked="" type="checkbox"/> Health	\$0.00
<input checked="" type="checkbox"/> Health Savings Account	\$0.00
<input checked="" type="checkbox"/> Health Care FSA	\$50.00
<input checked="" type="checkbox"/> Dependent Care FSA	\$0.00
<input checked="" type="checkbox"/> Dental	\$26.29
<input checked="" type="checkbox"/> Surrency Vision	\$0.00
<input checked="" type="checkbox"/> Basic Life & AD&D	\$0.00
<input checked="" type="checkbox"/> Short-Term Disability	\$18.20
<input checked="" type="checkbox"/> Trustmark Universal Life	\$15.89
<input checked="" type="checkbox"/> Trustmark Accident Insurance	\$12.89
<input checked="" type="checkbox"/> Allstate Critical Illness	\$0.00
<input type="checkbox"/> InfoArmor	\$0.00
Employer Cost \$599.17	
Pre-tax cost \$76.29	
Post-tax cost \$46.98	
Total Cost	\$123²⁷
Per Pay Period	

Back

Next

To enroll in Critical Illness coverage, indicate the tobacco/non-tobacco status that applies to you. Choose who to cover by clicking the corresponding radio button. Select the coverage amount by adjusting the slider. Then, click the "I wish to apply for coverage" radio button and click "Next" to enroll.

If you prefer to waive this coverage, click the "I wish to DECLINE this coverage" button and click "Next" to waive.

Allstate Critical Illness

Do you currently have any individual Critical Illness products with American Heritage Life (AHL)?

Yes No

Back

Next

Answer the questions when prompted, then click "Next" to continue.

Allstate Identity Protection

PRIVACY PLAN PLUS

Your Cost: Per Pay Period

Employee Only: **\$9.95**

Employee+Family: \$17.95

Covered People:
Curtis B. Allen, Allen

Enroll

DECLINE COVERAGE

You should only decline coverage if you are covered elsewhere. Declining coverage may require you to answer questions about your reasons for declining.

Your Cost: **\$0.00**

Decline

My Benefits	
<input checked="" type="checkbox"/> Health	\$61.99
<input type="checkbox"/> Health Care FSA	\$0.00
<input type="checkbox"/> Dependent Care FSA	\$0.00
<input checked="" type="checkbox"/> Dental	\$0.00
<input checked="" type="checkbox"/> Vision	\$7.04
<input checked="" type="checkbox"/> Basic Life & AD&D	\$0.00
<input checked="" type="checkbox"/> Short-Term Disability	\$36.40
<input type="checkbox"/> Trustmark Universal Life	\$0.00
<input type="checkbox"/> Trustmark Accident Insurance	\$0.00
<input type="checkbox"/> Allstate Benefits Critical Illness	\$0.00
<input checked="" type="checkbox"/> Allstate Identity Protection	\$0.00
<input checked="" type="checkbox"/> EAP Membership Plan	\$0.00
<hr/>	
Employer Cost	\$701.05
Pre-tax cost	\$69.03
Post-tax cost	\$36.40
 Total Cost	\$105⁴³
Total Per Pay Period	

To enroll in the Identity Theft plan, choose who you wish to cover by selecting the corresponding radio button and clicking “Enroll” or click “Decline” to waive coverage.

Your enrollment is not complete until you see **CONGRATULATIONS!** Continue to next page...

Sign and Submit

Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your pre-tax and post-tax contributions **per pay period** for each plan.

- **Are You Satisfied With Your Elections?** If you are satisfied with your choices, click on the "NEXT" button at the bottom of this screen to sign your Enrollment Verification Form electronically using your PIN.
- **Need to Make Some Changes?** If you wish to make any changes to your elections, click on the benefit plan name in the menu at the left.

Your Benefits

Plan	Description	Pretax Cost	Posttax Cost	Employer Paid
Health	Blue Saver QHDHP; EO	\$0.00	\$0.00	\$563.86
Health Savings Account	Waived			
Health Care FSA	\$100	\$50.00	\$0.00	\$0.00
Dependent Care FSA	Waived			
Dental	Delta Dental of Kansas; ES	\$26.29	\$0.00	\$33.51
Surency Vision	Waived			
Basic Life & AD&D	OneAmerica Basic Life and AD&D; \$20,000	\$0.00	\$0.00	\$1.80
Short-Term Disability	\$350	\$0.00	\$18.20	\$0.00
Trustmark Universal Life	Trustmark Universal Life Events Insurance; EO	\$0.00	\$15.89	\$0.00
Trustmark Accident Insurance	Trustmark Accident Insurance; EO	\$0.00	\$12.89	\$0.00
Allstate Critical Illness	10,000; EO	\$0.00	\$40.05	\$0.00
InfoArmor	Waived			
Total		\$76.29	\$87.03	\$599.17

Signatures Required

To complete your enrollment, you must sign the following forms. Press Next to begin signing forms.

Form Name	Status	Date Signed/Reviewed	Enroller Date Signed/Reviewed
OC-HH/LTC.205 KS R207 Outline of Coverage	Not Reviewed	N/A	N/A
1573 NWB 387 R 1111 Acknowledgement and Authorization to Obtain Information (Jerry Test)	Unsigned		N/A
I573-NWB-151_R10-17 Notice of Insurance Information Practices	Not Reviewed	N/A	N/A
ABR DISCLOSURE KS UL Disclosure Statement for Accelerated Benefits	Unsigned		
L-205 KS Application for Life Insurance	Unsigned		
L-205 Addendum to Application for Life Insurance	Unsigned		
A-607/A KS E Application for Accident Coverage	Unsigned		
A-607 Addendum	Unsigned		
SHSD Benefit Confirmation	Unsigned		N/A



Next

Review your elections to make sure that all of the information reflects the coverage you want and click "Next" to continue.

Your enrollment is not complete until you see **CONGRATULATIONS!**

Review / Sign Forms

Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your pre-tax and post-tax contributions **per pay period** for each plan.

- **Are You Satisfied With Your Elections?** If you are satisfied with your choices, click on the "NEXT" button at the bottom of this screen to sign your Enrollment Verification Form electronically using your PIN.
- **Need to Make Some Changes?** If you wish to make any changes to your elections, click on the benefit plan name in the menu at the left.

Your enrollment will not be complete until you review and sign the forms listed below. By entering your electronic signature below, you are giving your consent to the electronic signature (e-signature) process and authorization to use electronic records and electronic signatures connected with your enrollment. If you decline the e-signature process, you will not be able to complete your enrollment electronically.

Please review each document carefully and place a checkmark next to each before signing.

Form Name
<input checked="" type="checkbox"/> 1573 NWB 387 R 1111 Acknowledgement and Authorization to Obtain Information (Jerry Test)
<input checked="" type="checkbox"/> ABR DISCLOSURE KS UL Disclosure Statement for Accelerated Benefits
<input checked="" type="checkbox"/> L-205 KS Application for Life Insurance
<input checked="" type="checkbox"/> L-205 Addendum to Application for Life Insurance
<input checked="" type="checkbox"/> A-607/A KS E Application for Accident Coverage
<input checked="" type="checkbox"/> A-607 Addendum
<input checked="" type="checkbox"/> OC-HH/LTC.205 KS R207 Outline of Coverage
<input checked="" type="checkbox"/> 1573-NWB-151 R10-17 Notice of Insurance Information Practices

Employee: By clicking the *Sign Form* button, I am electronically signing the form listed above.



Check the boxes to electronically sign the applicable forms. You can review these forms by clicking on the hyperlinks. Click "Sign Form" to continue. You may or may not have all of the forms as seen in the screenshot above. The number of notices/forms you have to sign depends on the coverages you enroll in.

Your enrollment is not complete until you see **CONGRATULATIONS!**



Benefit Verification / Deduction Confirmation



Name		Employee ID	Date of Hire
Jerry Test		654987321	10/04/2018
Location	Department	Job Class	Pay Mode
SHHS	Default	Certified Staff 1	12
Work Phone	Home Phone	E-mail	
	(650) 454-5456	jcastillo@avantsb.com	

Reason for Completing Form

Address
123 This way Thistown, KS 665044654

Benefit Deduction Summary

Plan	Product	Cvg	Ded. Cycle	Amount Requested		Benefit Amount	Employer Cost	Employee Cost	
				Pending Cost	Pending Amount			Pre-tax	After-tax
Health	Blue Saver QHDHP	EO	12				563.86	0.00	0.00
Health Savings Account	Waived								
Health Care FSA	Flexible Spending Account	EO	12			100	0.00	50.00	0.00
Dependent Care FSA	Waived								
Dental	Delta Dental of Kansas	ES	12				33.51	26.29	0.00
Surency Vision	Waived								
Basic Life & AD&D	OneAmerica Basic Life and AD	EO	12			20,000	1.80	0.00	0.00
Short-Term Disability	Short-Term Disability	EO	12			350	0.00	0.00	18.20
Trustmark Universal Life	Trustmark Universal Life Event	EO	12			5,000	0.00	0.00	15.89
Trustmark Accident Insurance	Trustmark Accident Insurance	EO	12				0.00	0.00	12.89
Allstate Critical Illness	Allstate Critical Illness	EO	12			10,000	0.00	0.00	40.05
InfoArmor	Waived								
Total:							599.17	76.29	87.03

Enrollment Agreement / Payroll Deduction Authorization

- To the best of my knowledge and belief, all statements and answers made on this form and all associated application forms are true, complete, and correct
- I understand that omissions or misrepresentations in the information I have provided may constitute fraud and may result in my coverage being void.
- Pursuant to IRC § 125, "pre-tax" elections are irrevocable during the plan year. No changes to "pre-tax" elections are allowed during the plan year unless you experience a qualified change in status event. Qualified change in status events include: change in marital status, change in dependent status, change in employment status. You have 30 days from the date of the change to contact human resources to change your benefit elections.
- Upon acceptance by the insurers, I hereby authorize my Group to deduct from my earnings the amounts indicated above.
- My authorization shall continue thereafter until the earlier of (a) termination of my employment, (b) written notice from me cancelling this authorization, or (c) termination of the Payroll Deduction Plan.
- I understand that it is my responsibility to verify the deduction amounts from my paycheck and to notify my employer immediately of any discrepancies.
- I understand any unused balance in a Dependent Care or Health Care Reimbursement account in which I am enrolled will be forfeited under the "Use it or Lose it" rule. Expenses must be incurred during the plan year for which the election amount was redirected

Your total deduction per pay period...

Total Deduction
\$ 163.32

Employee Signature _____

Date _____

[Download Form](#)

Please enter your PIN below and click on "SIGN FORM" to complete your enrollment and submit your elections. By entering your PIN, you are electronically signing the Benefit Verification/Deduction Confirmation Form above. Please review it carefully before entering your PIN.

Complete your enrollment by inputting your PIN and clicking "Sign Form" Your enrollment is not complete until you see **CONGRATULATIONS!**

Sign/Submit Complete

Congratulations!

Your enrollment is now complete. You may log-in to the system at any time during the year to review your benefit elections.

Recap of Your Elections

Listed below is a recap of your elections including who is covered under each benefit plan and your named beneficiaries. **Scroll down to the bottom of this screen to view a list of your completed enrollment forms.**

 Health

Enrollment Details

Product Name: BlueSelect Plus PPO

Coverage Level: Employee + Children

Your enrollment is now complete.

If you have any questions about your benefits or the enrollment process please contact a SHSD Benefit Counselor at 844-259-4566 8:00am-5:00pm Monday through Friday.
