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Employee Enrollment Guide

Beech Grove City Schools

Website: www.aflacatwork.com

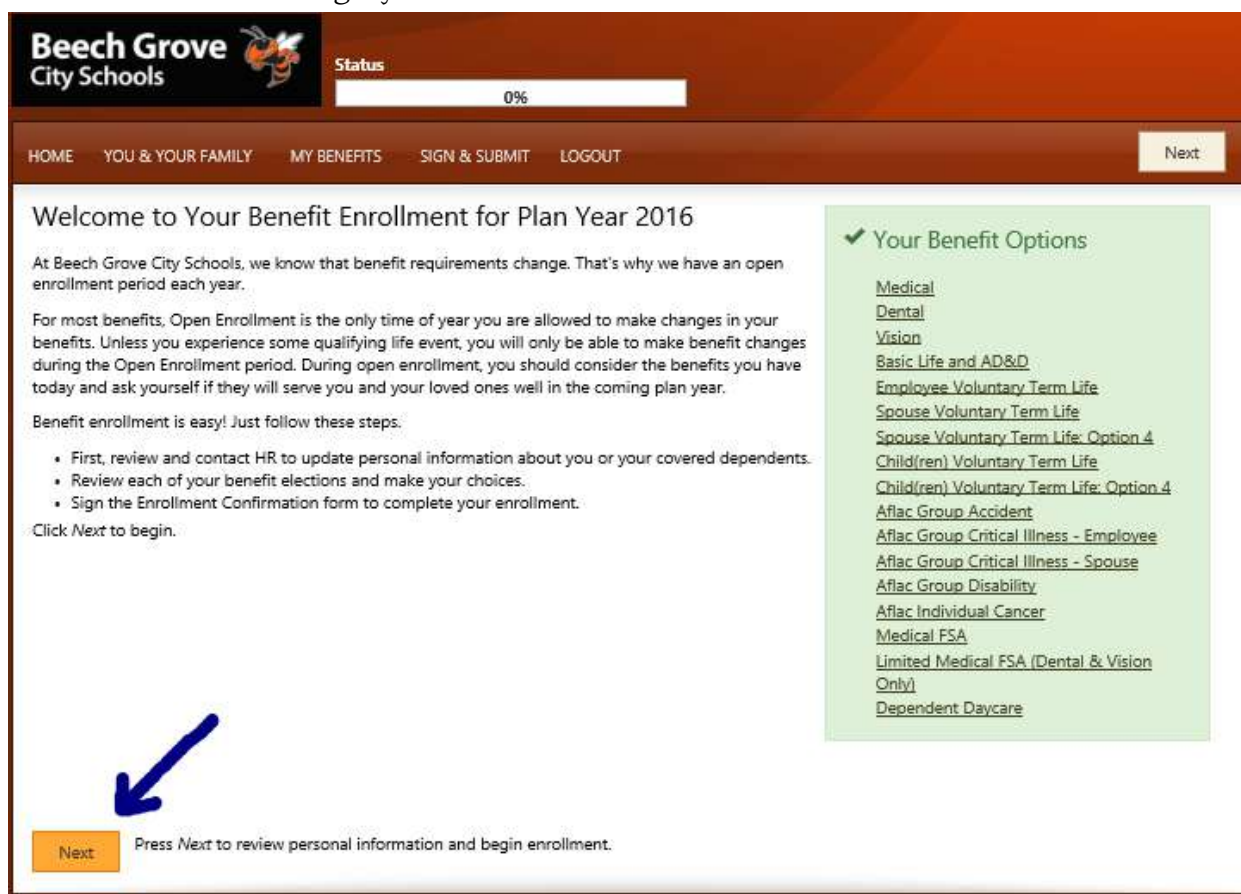
Login: Social Security Number (with or without dashes)

Pin: Last 4 digits of your SSN & the 2 Digit YEAR of your birth



The image shows the AflacAtWork Login: Enrollment page. At the top left is the Aflac logo. To the right, the text "AflacAtWork Login: Enrollment" is displayed. Below this is a banner image of a woman and a child. The main content area has a white background with a blue border. It contains a welcome message: "Welcome to AflacAtWork. To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN)." Below this, there are two input fields for "Returning applicants, log in:". The first field is labeled "Employee ID or Social Security Number:" and the second is labeled "Personal Identification Number (PIN):". A "LOGIN" button is positioned below these fields. To the right of the login fields, there is a blue box with the text "Is this your first visit? Have you forgotten your PIN?". Below the login fields, there are links for "Security Information" and "Privacy Policy". Further down, it says "Administrative users: login to the administrative site." At the bottom, there is copyright information: "© 2007 American Family Life Assurance Company of Columbus (Aflac) Portions © 2004-2014 Selerix Systems Inc. All rights reserved."

Once you click Log in, you will be taken to Beech Grove's personal enrollment site where you will need to click the NEXT button to begin your



The image shows the Beech Grove City Schools Benefit Enrollment for Plan Year 2016 page. At the top left is the Beech Grove City Schools logo. To the right, there is a "Status" section with a progress bar showing "0%". Below the logo, there is a navigation bar with links: "HOME", "YOU & YOUR FAMILY", "MY BENEFITS", "SIGN & SUBMIT", and "LOGOUT". A "Next" button is located in the top right corner. The main content area has a white background with a blue border. It contains a welcome message: "Welcome to Your Benefit Enrollment for Plan Year 2016". Below this, there is a paragraph explaining the enrollment process. Then, there is a list of steps to follow: "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.", and "Sign the Enrollment Confirmation form to complete your enrollment." Below the list, it says "Click Next to begin." To the right of the main content area, there is a green box titled "Your Benefit Options" with a list of links: "Medical", "Dental", "Vision", "Basic Life and AD&D", "Employee Voluntary Term Life", "Spouse Voluntary Term Life", "Spouse Voluntary Term Life: Option 4", "Child(ren) Voluntary Term Life", "Child(ren) Voluntary Term Life: Option 4", "Aflac Group Accident", "Aflac Group Critical Illness - Employee", "Aflac Group Critical Illness - Spouse", "Aflac Group Disability", "Aflac Individual Cancer", "Medical FSA", "Limited Medical FSA (Dental & Vision Only)", and "Dependent Daycare". At the bottom left, there is a blue arrow pointing to a "Next" button. To the right of the button, it says "Press Next to review personal information and begin enrollment."

PERSONAL INFORMATION: You will need to verify all of the Personal Information on this page and click NEXT. *(If any of the information is listed incorrectly, please contact Eileen McManus)*

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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:

Test

Tester

First

MI

Last

Suffix

Date of Birth:

12/26/1982

SSN:

***-**-4444

Gender:

☒ Male

☐ Female

DEPENDENTS: Please verify any dependents information or click the + sign to add dependents not currently listed.

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.

No Dependent Information Available

Name	SSN	DOB	Sex	Relation	+
No data available in table					

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Next

ADDING A DEPENDENT: Please enter ALL information on the dependent and click SAVE to proceed.

Continue the same process for each dependent that you need to cover. *(Please Note. Social Security Numbers ARE REQUIRED for each dependent. You will not be able to SAVE and proceed without entering all of the REQUIRED information first)*

Add Dependent

 Add information on your dependents below. Optional fields are marked in *italics*.

Relationship: Spouse ▼

Name:
First MI Last Suffix

Date of Birth:

SSN:

Gender: ☐ Male ☒ Female

Full-time Student: ☐ Yes ☒ No

Disabled: ☐ Yes ☒ No

Address: ☒ Same as employee

USA ▼

Country

123 CP

Street

Street (cont.)

CP IN ▼ 46123-

City

State

Zip

Save

Cancel

EMPLOYMENT: On this page, you will need to verify your Employment information and click NEXT to proceed. *(If any of the information is listed incorrectly, please contact Eileen McManus)*

i Please review and correct your employment information shown here. Optional items are shown in *italics*.

Certain items require additional information from you. These items are highlighted and underlined. Click on the item to correct it, if necessary.

Press *Next* to continue.

Date of Hire: 5/15/2016

Eligibility Date: 5/15/2016

Location: ADMIN

Department: SECRETARY

Job Class: CLASSIFIED 1

Title:

Salary: \$25,000.00

Pay group: 26 pay/24 deductions

Payroll Frequency: BiWeekly

Hours per Week:

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MY BENEFITS: This page shows you all of the Benefits that you are eligible to enroll in for the current Enrollment Period. Click on Review under each Benefit to either Enroll in the plan or Waive the plan.

[HOME](#) [YOU & YOUR FAMILY](#) [MY BENEFITS](#) [SIGN & SUBMIT](#) [LOGOUT](#) [Back](#) [Next](#)

My Benefits

Below is a list of your current benefit elections. Click "Review" for benefit information and to elect or decline coverage.

☒ **Medical** [Review](#)
Plan Name: Medical **Coverage Level:** Employee Only

First Name	MI	Last Name	DOB	Sex	Relationship
Test		Tester	12/26/1982	M	Employee

☒ You have completed enrollment in this plan. Your cost per pay period will be **\$115.75**

☒ **Dental** [Review](#)
You have elected to WAIVE coverage under this plan.

☒ **Vision** [Review](#)
Plan Name: Vision **Coverage Level:** Employee Only

First Name	MI	Last Name	DOB	Sex	Relationship
Test		Tester	12/26/1982	M	Employee

☒ You have completed enrollment in this plan. Your cost per pay period will be **\$3.12**

My Benefits

☒ Medical
☒ Dental
☒ Vision
☒ Basic Life and AD&D
☐ Employee Voluntary Term Life
☐ Spouse Voluntary Term Life
☐ Spouse Voluntary Term Life: Opti
☐ Child(ren) Voluntary Term Life
☐ Child(ren) Voluntary Term Life: Op
☐ Aflac Group Accident
☐ Aflac Group Critical Illness - Empli
☐ Aflac Group Critical Illness - Spou
☐ Aflac Group Disability
☐ Aflac Individual Cancer
☐ Medical FSA
☐ Limited Medical FSA (Dental & Vi
☐ Dependent Daycare

Employer Cost **\$232.75**
Pre-tax cost: **\$118.87**
Post-tax cost: **\$0.00**
Employee total cost: **\$118.87**

(Please Note: You will only be able to select the benefits for Employee Only if you have not yet entered your dependents)

Medical

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.

	Employee Only	Employee + Spouse	Employee + Children	Employee+Family
Plan 2	<input checked="" type="radio"/> \$115.75	<input type="radio"/> \$371.25	<input type="radio"/> \$333.25	<input type="radio"/> \$478.42
Plan 3	<input type="radio"/> \$49.25	<input type="radio"/> \$229.25	<input type="radio"/> \$183.16	<input type="radio"/> \$312.42
Plan 4	<input type="radio"/> \$30.34	<input type="radio"/> \$144.66	<input type="radio"/> \$92.16	<input type="radio"/> \$198.92
Plan 5	<input type="radio"/> \$19.92	<input type="radio"/> \$439.00	<input type="radio"/> \$414.50	<input type="radio"/> \$515.50

- ☒ I wish to apply for this coverage
☐ I WISH TO WAIVE THIS COVERAGE

My Benefits

☐ Medical
☒ Dental
☒ Vision
☒ Basic Life and AD&D
☐ Employee Voluntary Term Life
☒ Spouse Voluntary Term Life
☒ Spouse Voluntary Term Life: Optic
☒ Child(ren) Voluntary Term Life
☒ Child(ren) Voluntary Term Life: Op
☐ Aflac Group Accident
☐ Aflac Group Critical Illness - Empl
☒ Aflac Group Critical Illness - Spou

If you need to go back to enter your Dependents information, click on the You & Your Family on the top of the page and scroll to Dependents. This will bring you back to the DEPENDENTS page. Once you have entered your Dependents information, you can click on the MY BENEFITS tab at the top and scroll to the benefit that you need to enroll in.

HOME **YOU & YOUR FAMILY** MY BENEFITS SIGN & SUBMIT LOGOUT Back Next

Medical

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.

	Employee Only	Employee + Spouse	Employee + Children	Employee+Family
Plan 2	<input checked="" type="radio"/> \$115.75	<input type="radio"/> \$371.25	<input type="radio"/> \$333.25	<input type="radio"/> \$478.42
Plan 3	<input type="radio"/> \$49.25	<input type="radio"/> \$229.25	<input type="radio"/> \$183.16	<input type="radio"/> \$312.42
Plan 4	<input type="radio"/> \$30.34	<input type="radio"/> \$144.66	<input type="radio"/> \$92.16	<input type="radio"/> \$198.92
Plan 5	<input type="radio"/> \$19.92	<input type="radio"/> \$439.00	<input type="radio"/> \$414.50	<input type="radio"/> \$515.50

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My Benefits

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☐ Aflac Group Critical Illness - Empl
☒ Aflac Group Critical Illness - Spou

By clicking NEXT after each benefit, you will be taken through the entire enrollment process. **Please click APPLY or DECLINE for each benefit to proceed to the next benefit.**

There will be notes in **RED** throughout the enrollment process for some of the benefit offerings, please pay close attention to those notes as there may be some additional paperwork that you will need to print off, sign and turn in to **Eileen McManus** to finalize your enrollment.

Review your plan and make any changes to the benefit amounts that is provided by your employer.

NOTE: At age 70, the benefit amount reduces by 50%.


Short Term Disability

Please select the desired waiting period (7 or 14 days) and then select the desired benefit amount.

NOTE: If you are applying for this coverage for the first time and are not newly hired, you will be subject to health questions in order to receive this benefit.

NOTE: If you currently have coverage and would like to increase your benefit amount greater than the annual \$100 guaranteed issue amount (based on salary), you will be subject to health questions in order to receive the coverage elected.

SIGN & SUBMIT: Once you have reviewed each benefit, you will be brought to the Sign & Submit page. Here, you will need to review each benefit, the cost per pay and the totals.

Beech Grove City Schools

Status

92%

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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.

Plan	Description	Pretax Cost	Posttax Cost	Employer Paid
Medical	Plan 2; EO	\$115.75	\$0.00	\$231.25
Dental	Waived			
Vision	Vision; EO	\$3.12	\$0.00	\$0.00
Basic Life and AD&D	\$20,000	\$0.00	\$0.00	\$1.50
Employee Voluntary Term Life	Waived			
Spouse Voluntary Term Life	Waived			
Spouse Voluntary Term Life: Option 4	Waived			
Child(ren) Voluntary Term Life	Waived			
Child(ren) Voluntary Term Life: Option 4	Waived			
Aflac Group Accident	Waived			
Aflac Group Critical Illness - Employee	Waived			

You will have an option to change any and all benefits at this point by going to the top of the screen and click MY BENEFITS. Scroll to the benefit that you need to make changes to and click on it.

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Medical

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.

	Employee Only	Employee + Spouse	Employee + Children	Employee+Family
Plan 2	<input checked="" type="radio"/> \$115.75	<input type="radio"/> \$371.25	<input type="radio"/> \$333.25	<input type="radio"/> \$478.42
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Plan 4	<input type="radio"/> \$30.34	<input type="radio"/> \$144.66	<input type="radio"/> \$92.16	<input type="radio"/> \$198.92
Plan 5	<input type="radio"/> \$19.92	<input type="radio"/> \$439.00	<input type="radio"/> \$414.50	<input type="radio"/> \$515.50

☒ I wish to apply for this coverage
☐ I WISH TO WAIVE THIS COVERAGE

My Benefits

- ☐ Medical
- ☒ Dental
- ☒ Vision
- ☒ Basic Life and AD&D
- ☐ Employee Voluntary Term Life
- ☒ Spouse Voluntary Term Life
- ☒ Spouse Voluntary Term Life: Optic
- ☒ Child(ren) Voluntary Term Life
- ☒ Child(ren) Voluntary Term Life: Op
- ☐ Aflac Group Accident
- ☐ Aflac Group Critical Illness - Empl
- ☒ Aflac Group Critical Illness - Spou

If you need to make changes, click UNLOCK and may desired changes to each plan. Make sure to click NEXT once you have made your changes.

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Unlock

Medical

Plan Name: Medical **Coverage Level:** Employee Only

First Name	MI	Last Name	DOB	Sex	Relationship
Test		Tester	12/26/1982	M	Employee

My Benefits

- ☒ Medical
- ☒ Dental
- ☒ Vision

You will be brought back to the SIGN AND SUBMIT page after each change is made. Once you are ready to complete your enrollment, click NEXT.

You will need to enter your PIN (*Last 4 Digits of your SSN & the 2 digit YEAR of your birth*) and click SIGN FORM to proceed to the next form that will need to be signed.

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.

PIN:

REVIEW / SIGN FORMS: Once you have reviewed your Benefit Verification / Deduction Confirmation, you will need to enter your PIN and click SIGN FORM. This will finalize your enrollment choices and submit them to the Benefits Carriers as well as your Payroll Dept.

Review / Sign Forms

Benefit Verification / Deduction Confirmation

Name	SSN	Employee ID	Date of Hire	Reason for Completing Form
Charlene Jordan	000000	000000	04/15/2016	
Location	Department	Job Class	Pay Mode	Address
CCPS	Central	CLASSIFIED-105	24	123 CP Co, IN 45123
Work Phone	Home Phone	E-mail		
(812) 335-6101		Charlene.jordan@ccps.com		

Benefit Deduction Summary

Plan	Product	Cvg	Benefit Amount	Ded. Cycle	Employer Cost	Employee Cost Pre-tax	Employee Cost Post-tax
Medical	Catastrophic	EO		24	119.00	67.00	00
Dental	Dental	EO		24	10.00	8.00	00
Vision	Vision	EO		1	160.00	1.00	00
Health Care FSA	Voluted						
Limited Care FSA (Dental/Vision Only)	Voluted						
Dependent Care FSA	Voluted						
Basic Life and AD&D	Basic Life and AD&D	EO	559000.00	1		.00	1.00
Long Term Disability	Long Term Disability (Bird over Paid)	EO	\$2777.02	1		.00	1.00
Short Term Disability	Short Term Disability	EO	\$2000.00	24		.00	20.40
Optional Term Life	Employee Voluntary Term Life	EO	559000.00	24		.00	51.00
Reverse Credit Lines	Voluted						
Total:					246.00	68.00	52.40

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 § 135, "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 changes 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 deducted.

Your total deductions per pay period...

Total Deductions
\$ 140.43

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.

PIN:

Sign Form

CONGRATULATIONS! You have now completed your enrollment!

You may now click LOGOUT or Scroll to the bottom of the screen to view all of your chosen benefits.

Should you have any questions, please contact:

Eileen McManus – Beech Grove City Schools

Michael Blink – Steele Benefits



Steele Benefit Services
9020 Crawfordsville Road
Indianapolis, IN 46234
317-286-6121