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# **Employee Enrollment Guide**

**Beech Grove City Schools**

Website: [www.aflacatwork.com](http://www.aflacatwork.com)

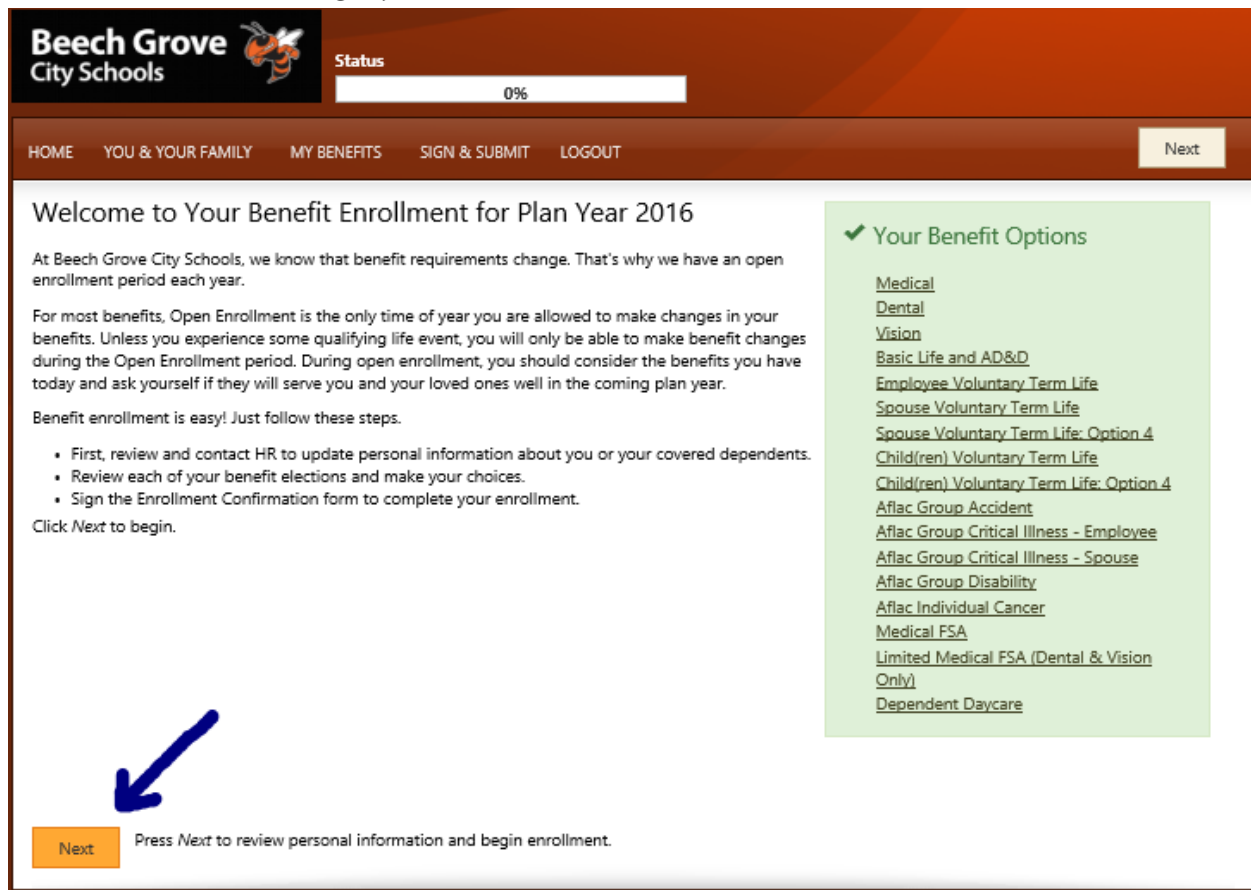
Login: Social Security Number (with or without dashes)

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



The image shows the AflacAtWork Login: Enrollment page. It features the Aflac logo in the top left and a header with the text "AflacAtWork Login: Enrollment". Below the header is a photograph of a woman hugging a child. The main content area is a white box 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 is a section for "Returning applicants, log in:" with two input fields: "Employee ID or Social Security Number:" and "Personal Identification Number (PIN):". A "LOGIN" button is positioned below the fields. To the right of the login fields is a blue box with the text "Is this your first visit? Have you forgotten your PIN?". Below the login fields are links for "Security Information" and "Privacy Policy". At the bottom of the white box, it says "Administrative users: login to the administrative site." and "© 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 enrollment page. It features the Beech Grove City Schools logo in the top left and a "Status" bar showing "0%". Below the logo is a navigation menu with links for "HOME", "YOU & YOUR FAMILY", "MY BENEFITS", "SIGN & SUBMIT", and "LOGOUT". A "Next" button is located in the top right corner. The main content area is titled "Welcome to Your Benefit Enrollment for Plan Year 2016" and contains the following text: "At Beech Grove City Schools, 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." Below this text is a list of 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." Below the list is the text "Click Next to begin." To the right of the main content area is a green box titled "Your Benefit Options" with a checkmark icon. It contains a list of benefit options: "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 of the page is a blue arrow pointing to a "Next" button. Below the "Next" button is the text "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)*

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

### Personal Information

**i** 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:      
First MI Last Suffix

Date of Birth:

SSN:

Gender:  Male  Female

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

### Dependents

**i** 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					

Back 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:

Name:      
First MI Last Suffix

Date of Birth:

SSN:

Gender:  Male  Female

Full-time Student:  Yes  No

Disabled:  Yes  No

Address:  Same as employee

Country

Street

Street (cont.)

City State Zip

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:

Back

Next

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

### 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

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
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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  
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My Benefits

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- Employee Voluntary Term Life
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- Spouse Voluntary Term Life: Optic
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- Child(ren) Voluntary Term Life: Op
- Aflac Group Accident
- 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.

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.


Status 92%

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

## 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.

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

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

My Benefits

- Medical
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- 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.

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

Back



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

<b>Name</b>	<b>SSN</b>	<b>Employee ID</b>	<b>Date of Hire</b>	<b>Reason for Completing Form</b>
Classified Team	000000	000000	00/00/00	
<b>Location</b>	<b>Department</b>	<b>Job Class</b>	<b>Pay Mode</b>	<b>Address</b>
OPS	Classified	CLASSIFIED-105	20	123 CP Co., IN 45123
<b>Work Phone</b>	<b>Home Phone</b>	<b>E-mail</b>		
	(202) 200-6000	lasky3@csd-benefit.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	110.00	47.00	.00
Dental	Dental	EO		24	10.00	8.00	.00
Vision	Vision	EO		1	160.00	1.00	.00
Health Care FSA	Wellnet						
Limited Care FSA (Dental/Vision Only)	Wellnet						
Dependent Care FSA	Wellnet						
Basic Life and AD&D	Basic Life and AD&D	EO	50000.00	1		.00	1.00
Long Term Disability	Long Term Disability (Employer Paid)	EO	\$2777.02	1		.00	1.00
Short Term Disability	Short Term Disability	EO	\$2700.00	24		.00	20.40
Optional Term Life	Employee Voluntary Term Life	EO	\$20000.00	24		.00	51.00
Group Critical Illness	Wellnet						
<b>Total:</b>					<b>396.00</b>	<b>54.00</b>	<b>62.40</b>

#### 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 withheld.

**Your total deductions per pay period...** **Total Deductions**  
**\$ 140.40**

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**