

Employee Enrollment Guide

Beech Grove Schools

Website: www.aflacatwork.com

Login, Social Security Number (without dashes)

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

Aflac.

AflacAtWork Login: Enrollment



123-45-6789

Welcome to **AflacAtWork**. To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN).
678982

Returning applicants, log in:

Employee ID or Social Security Number

Personal Identification Number (PIN)

LOGIN

[Security Information](#) [Privacy Policy](#)

Administrative users: login to the [administrative site](#).

© 2007 American Family Life Assurance Company of Columbus (Aflac)
Portions © 2004-2014 Selerix Systems Inc. All rights reserved.

[Is this your first visit?](#)
[Have you forgotten your PIN?](#)

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 enrollment.

Beech Grove City Schools (33% Complete)

Home You & Your Family My Benefits Sign & Submit Logout **Next**

Welcome to Your Benefit Enrollment for Plan Year 2017

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.

- 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

- [Medical](#)
- [Dental](#)
- [Vision](#)
- [Health Savings Account](#)
- [Basic Life and AD&D](#)
- [Long Term Disability](#)
- [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](#)
- [Limited Medical FSA \(Dental & Vision Only\)](#)

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

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 HR)*

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

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

Marital Status:

Date of Birth:

SSN:

Gender: Male Female

Contact Info

Address:
Country

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

Dependents

1 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					

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.

Add Dependent

i 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

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.

My Benefits

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

<input type="checkbox"/> Medical You have to complete enrollment in this plan.	Review
<input type="checkbox"/> Dental You have to complete enrollment in this plan.	Review
<input type="checkbox"/> Vision You have to complete enrollment in this plan.	Review
<input type="checkbox"/> Basic Life and AD&D You have to complete enrollment in this plan.	Review
<input checked="" type="checkbox"/> Long Term Disability	Review

Benefit Amount	Cost
\$2,777.92 (66.67 x salary)	\$1.00

My Benefits	
<input type="checkbox"/> Medical	
<input type="checkbox"/> Dental	
<input type="checkbox"/> Vision	
<input type="checkbox"/> Basic Life and AD&D	
<input checked="" type="checkbox"/> Long Term Disability	
<input type="checkbox"/> Short Term Disability	
<input type="checkbox"/> Optional Term Life	
<input checked="" type="checkbox"/> Spouse Voluntary Term Life	
<input checked="" type="checkbox"/> Child(ren) Voluntary Term Life	
Employer Cost	\$0.00
Pre-tax cost	\$0.00
Post-tax cost	\$1.00
Employee total cost	\$1.00

(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 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 button to continue.

PLAN 2

Your Cost: Per Pay Period

Employee Only: **\$100.34**

Employee + Children: \$315.67

Employee + Spouse: \$381.82

Employee + Family: \$475.42

Covered People:
Blink Test

Enroll

PLAN 3

Your Cost: Per Pay Period

Employee Only: **\$63.83**

Employee + Children: \$181.09

Employee + Spouse: \$239.67

Employee + Family: \$312.42

Covered People:
Blink Test

Enroll

Recommended
PLAN 4

Your Cost: Per Pay Period

Employee Only: **\$30.33**

Employee + Children: \$92.16

Employee + Spouse: \$144.67

Employee + Family: \$198.92

Covered People:
Blink Test

Enroll

My Benefits

<input checked="" type="checkbox"/> Medical	\$0.00
<input checked="" type="checkbox"/> Dental	\$1.92
<input checked="" type="checkbox"/> Vision	\$0.00
<input type="checkbox"/> Basic Life and AD&D	\$0.00
<input type="checkbox"/> Long Term Disability	\$0.00
<input type="checkbox"/> Employee Voluntary Term Life	\$0.00
<input type="checkbox"/> Spouse Voluntary Term Life	\$0.00
<input type="checkbox"/> Spouse Voluntary Term Life - Option 4	\$0.00
<input type="checkbox"/> Child(ren) Voluntary Term Life	\$0.00
<input type="checkbox"/> Child(ren) Voluntary Term Life - Option 4	\$0.00

Employer Cost \$17.94

Pre-tax cost \$1.92

Post-tax cost \$0.00

Total Cost **\$1.92**

Per Pay Period

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.

The screenshot shows a web interface for managing benefits. At the top, there are navigation tabs: Home, You & Your Family, My Benefits, Sign & Submit, and Logout. A dropdown menu is open under 'My Benefits', with 'Dependents' highlighted and a red arrow pointing to it. Below the menu, there are instructions and an 'Enroll' button. The main content area displays three plan options: PLAN 2, PLAN 3, and PLAN 4. Each plan has a table of costs for different coverage levels (Employee Only, Employee + Children, Employee + Spouse, Employee + Family) and an 'Enroll' button. PLAN 4 is highlighted in blue. To the right, a 'My Benefits' summary box shows a list of selected benefits and their costs, with a total cost of \$192.

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 HR 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.

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	Catastrophic; EO	\$47.50	\$0.00	\$113.00
Dental	Dental; EO	\$9.50	\$0.00	\$13.50
Vision	Vision; EO	\$1.00	\$0.00	\$168.00
Basic Life and AD&D	50,000; EO	\$0.00	\$1.00	\$0.00
Long Term Disability	Long Term Disability (Employer Paid); \$2,777.92	\$0.00	\$1.00	\$0.00
Short Term Disability	\$2,700	\$0.00	\$29.43	\$0.00
Optional Term Life	\$200,000	\$0.00	\$51.00	\$0.00
Spouse Voluntary Term Life	N/A			
Child(ren) Voluntary Term Life	N/A			
Total		\$58.00	\$82.43	\$294.50

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

Form Name	Status	Date Signed/Reviewed
Short Term Disability App 	Unsigned	
Voluntary Life Application 	Unsigned	
Voluntary Life EOI 	Not Reviewed	
Benefit Verification 	Unsigned	

Next

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

Medical

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** button to continue.

PLAN 2 PLAN 3 **PLAN 4** Recommended

My Benefits	
<input type="radio"/> Medical	\$0.00
<input checked="" type="radio"/> Dental	\$1.92
<input checked="" type="radio"/> Vision	\$0.00
<input type="radio"/> Basic Life and AD&D	\$0.00
<input type="radio"/> Long Term Disability	\$0.00
<input type="radio"/> Employee Voluntary Term Life	\$0.00
<input type="radio"/> Employee Voluntary Term Life	\$0.00
<input type="radio"/> Employee Voluntary Term Life	\$0.00

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

Vision

Here is a summary of your current Vision election. If you wish to make a change, click the *Unlock* button.

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

First Name	MI	Last Name	DOB	Sex	Relationship
Classified		Testerr	1/1/1960	M	Employee

Back Next **Unlock** Vision is now locked. If you wish to make changes, press the *Unlock* button.

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.

City State ZIP Month Day Year
Classified Tester
Signature of Employee Printed Name of Employee

USIC-2020EE

Page 1

STD 1208

[Download Form](#)

Employee: By entering my PIN below and clicking the *Sign Form* button, I am electronically signing the form listed above.

PIN:

Sign Form

Back

Skip Form

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. You will receive an email with a copy of this confirmation.

Review / Sign Forms

Benefit Verification / Deduction Confirmation

Name	SSN	Employee ID	Date of Hire	Reason for Completing Form
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	MM/DD/YYYY	
Location	Department	Job Class	Pay Mode	Address
0000	0000	XXXXXXXXXX	00	
Work Phone	Home Phone	Email	123 CP Co, IN 45123	
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX		

Benefit Deduction Summary

Plan	Product	Env	Benefit Amount	End. Cycle	Employer Cost	Employee Cost Pre-tax	Employee Cost Post-tax
Medical	XXXXXXXXXX	EM		11	100.00	100.00	0.00
Dental	Dental	EM		11	15.00	15.00	0.00
Vision	Vision	EM		1	100.00	100.00	0.00
Health Care FSA	Health Care FSA	EM					
Dependent Care FSA	Dependent Care FSA	EM					
Life Insurance	Life Insurance	EM					
Accident and Sickness Indemnity	Accident and Sickness Indemnity	EM					
Long Term Disability	Long Term Disability	EM	10000.00	1			100.00
Short Term Disability	Short Term Disability	EM	10000.00	1			100.00
Disability Income Protection	Disability Income Protection	EM	10000.00	1			100.00
Health Savings Account	Health Savings Account	EM					
Total:					215.00	215.00	0.00

Enrollment Agreement / Payroll Deduction Authorization

I, the undersigned, hereby authorize the Employer to deduct from my pay the amounts specified in the attached Payroll Deduction Summary for the following benefits:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Health Care FSA
- Dependent Care FSA
- Life Insurance
- Accident and Sickness Indemnity
- Long Term Disability
- Short Term Disability
- Disability Income Protection
- Health Savings Account

I understand that the Employer is not responsible for the deductibility of these amounts from my pay. I understand that the Employer is not responsible for the deductibility of these amounts from my pay. I understand that the Employer is not responsible for the deductibility of these amounts from my pay.

Your total deductions per pay period... **\$ 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:

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

Michael Blink – Steele Benefits



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

