



# Making Changes to your Beneficiaries

These instructions will help you navigate through BenefitBridge in making your changes to your Beneficiaries

The screenshot shows the BenefitBridge user interface. At the top left is the County of Sacramento logo and "Active Employees" text. At the top right is "ALL PLANS". The main header features the BenefitBridge logo and a photo of a woman and a child. Below the header are two columns: "USER LOGIN" with fields for "User Name" and "Password", and "NEW USER" with a "REGISTER" button and "NEED HELP?" section containing support contact information.

COUNTY OF SACRAMENTO  
Active Employees

ALL PLANS

BenefitBridge  
A Keenan Solution

**USER LOGIN**

User Name

Password

**LOGIN** [Forgot User Name / Password?](#)

**NEW USER**

**REGISTER** Create a User Name and Password to access your account.

**NEED HELP?**

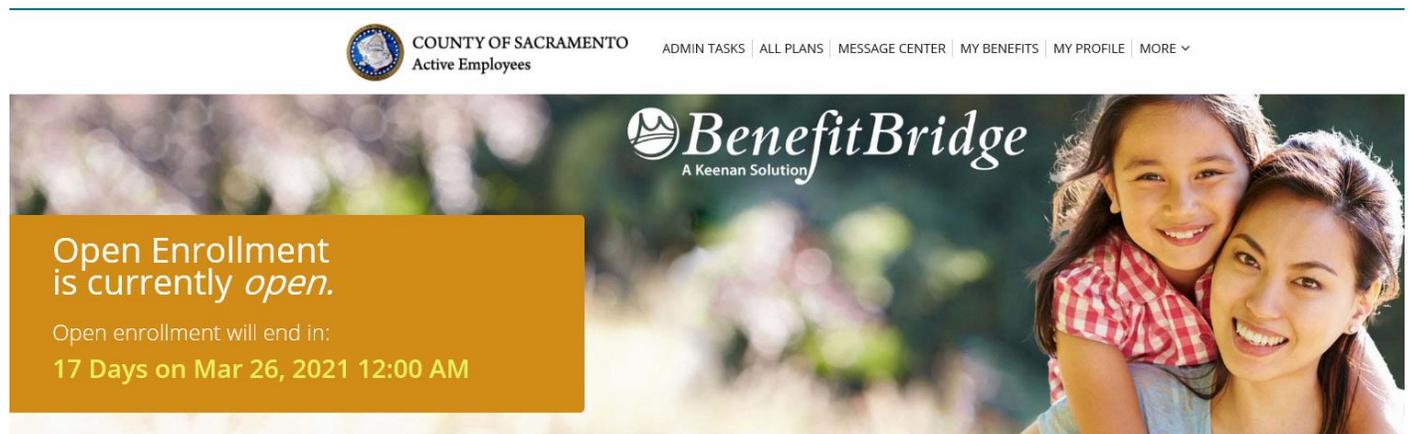
- Contact BenefitBridge Support
- Monday thru Friday 8:00am - 5:00pm (PST)
- (800) 814-1862
- [benefitbridge@keenan.com](mailto:benefitbridge@keenan.com)

Start by navigating to the website at [www.benefitbridge.com/saccounty](http://www.benefitbridge.com/saccounty)

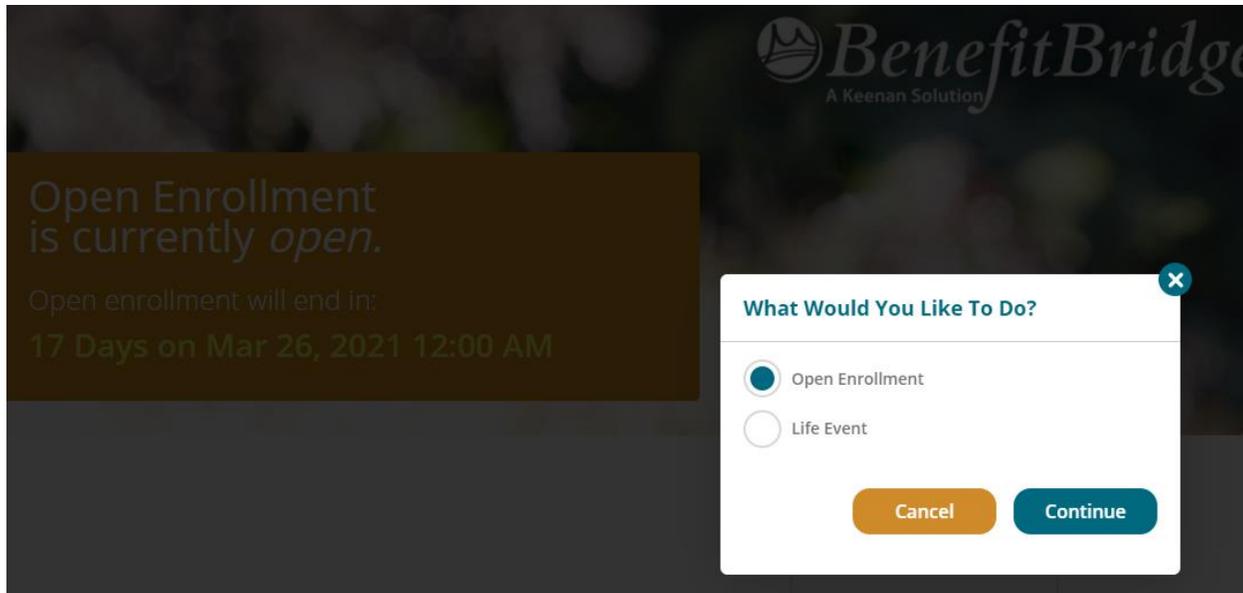
Please log on using your User Name and Password. If you have forgot your user name and password, please click on the link next to the LOGIN button.



Once you have logged on, close the pop up window by clicking on the "X" in the top corner. You then will click **Make Changes to My Benefits**, highlighted below, to make changes.



Then, select **OPEN ENROLLMENT** in the pop up window. Then, hit continue.



You will then be taken to a screen showing your Employee Information.

[View/Change Details](#)

EMPLOYEE
DEPENDENTS
BENEFITS
SUMMARY

## EMPLOYEE INFORMATION

- Change the desired information and select **Continue** to update. Please contact the appropriate department within your organization for any information you are unable to change.

*\*Indicates required fields*

\* **FIRST NAME:**  **MIDDLE NAME:**

At the bottom of the screen is a "Continue" button. Please hit continue, and you will be taken to the **DEPENDENTS** page.



### Open Enrollment

- EMPLOYEE ✓
- DEPENDENTS
- BENEFITS
- SUMMARY

## DEPENDENTS

**REQUIRED DOCUMENTATION:** A marriage certificate/birth certificate/state registration must be submitted to the Benefits Office within 7 days of completing your enrollment or coverage for your dependent will not be approved.

- If you wish to remove coverage for a dependent, select **Continue** to proceed to the Benefits enrollment page.

Show More ▾

Add Dependent

DEPENDENT	SSN	RELATION	AGE	OPTIONS
<input type="text"/>	** -0000	SPOUSE	48	Select ▾

Please provide documentation if required by your Employer

Add Document

Cancel

Continue

Hit continue as you will not be making any changes to your dependents.

You will then be brought to the Voluntary Term Life page. You will see your current Prudential insurance and the new Voya insurance with the same coverage amount.

**Open Enrollment**

- EMPLOYEE ✓
- DEPENDENTS ✓
- VOLUNTARY TERM LIFE ✓**
- GROUP TERM LIFE ✓
- CRITICAL ILLNESS
- SUMMARY

*\* Required Enrollment*  
✓ Selection Completed

**Plans Selected (2 of 3)**  
Sub Total: **\$8.17** / PAY PERIOD

2021-BG80-TIRB

**Last Year You Chose**

PLAN	COST PER PAY PERIOD
<input type="checkbox"/> Compare Prudential Optional Life-Option 5	<b>\$11.76</b> (24 deductions per year)

COVERED	RELATION	COVERAGE
[Redacted]	EMPLOYEE	\$368,000
[Redacted]	SPOUSE	\$250,000

**This Year's Coverage Options**  
Options available to you are shown in the "Plan" Options.

- Option A - 1x annual salary up to \$50,000 (including your basic coverage).
- VOYA Voluntary Term Life - you can elect up to 7 times your annual salary up to \$1,000,000, plus your basic coverage.

This coverage would pay the beneficiary(ies) tax-free money in the event of death. The dependent life coverage would pay you the loss of a Spouse/Domestic Partner/Dependent.

Hide ▲

PLAN	COST PER PAY PERIOD	
<b>Enrolled Plan</b> VOYA FINANCIAL Voya-Voluntary Term Life (5 x salary)	<b>\$8.17</b> (24 deductions per year) Clear Change	
<b>Guaranteed Coverage: \$368,000</b>		
NAME	RELATION	COVERAGE
[Redacted]	SPOUSE	Guaranteed : \$250,000

Add/Change Beneficiaries and Distribution **+**

<input type="checkbox"/> Compare	<b>\$0.00</b> (24 deductions per year) Select
VOYA FINANCIAL VOYA-Optional Life Optional Life Option 1A. ( With 18K)	

Cancel **Continue**

To make add or make changes to your beneficiaries , you will want to hit the "+" button.

You will then be asked to designate your beneficiaries. You may see beneficiaries listed that are no longer valid. While you can't delete them, just set them to "0" in the distribution and they will not be considered a beneficiary.

Active Employees

## Your Beneficiaries

Primary and Secondary must each add up to 100%

Current Coverage Amount \$421,000

- Select primary and/or secondary beneficiaries and enter distribution percentages
- To add a beneficiary not listed, select **Add Beneficiary**.
- The beneficiary information contained within BenefitBridge will replace all prior beneficiary designations. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new BenefitBridge enrollment:
  - This Beneficiary Designation/Change is immediately effective recorded by the BenefitBridge system.
  - If you are married, your spouse may have a legal interest in this designation of beneficiary. A beneficiary can be challenged if your spouse receives less than their proportionate share of the benefit attributable to community property.
  - If you are married and designate your spouse as a beneficiary and later divorce, upon your death, your beneficiary designation of your spouse will be deemed revoked.
  - You will need to submit a new Beneficiary Designation/Change to designate a new beneficiary(ies). If, upon your death, you have not designated a new beneficiary, benefits will be paid in accordance with the terms of certain Group Contract providers, plan terms, or California laws governing probate and estates.
  - If you name a minor child under the age of 18, the insurer will have to ask a court to appoint a guardian to receive the benefits. However, you may name a custodian for the minor child but you must include the following language in the relationship field "As Custodian for [name of child] under the California Uniform Transfers to Minors Act."
  - Payment will be made to the named beneficiary. If you do not name a beneficiary, or the named beneficiary(ies) predeceases you, benefits will be paid in accordance with the terms of the Group Contract, the plan documents and California laws governing probate and estates.

NAME	RELATION	BENEFICIARY	DISTRIBUTION	OPTIONS
<input type="text"/>	<input type="text" value="SPOUSE"/>	<input type="text" value="Select one"/> ▼	<input type="text" value="0 %"/>	
<input type="text"/>	<input type="text" value="SPOUSE"/>	<input type="text" value="Select one"/> ▼	<input type="text" value="0 %"/>	

If they are already listed, just change the “beneficiary” drop down to “Primary” and enter 100 into the “distribution” column. If you have more than one person as a beneficiary, you will mark them as Primary and then enter the percentage you want them to receive. All primary beneficiaries must 100% between them.

If you need to add them, just select the “Add Beneficiary” button. You can have an individual, a trust, or a charity as a beneficiary. You will then need to enter the information for them:

### Beneficiary Details

BENEFICIARY TYPE:

INDIVIDUAL  TRUST  CHARITY/ORGANIZATION

\*FIRST NAME:

MIDDLE INITIAL:

\*LAST NAME:

\*DATE OF BIRTH:

\*SOCIAL SECURITY NUMBER:

\*RELATION:

GENDER:

MALE  FEMALE

ADDRESS 1:

ADDRESS 2:

CITY:

STATE:

ZIP:

\*PHONE NUMBER:

### Beneficiary Details

BENEFICIARY TYPE:

INDIVIDUAL  TRUST  CHARITY/ORGANIZATION

\*NAME OF CHARITY/ORGANIZATION:

ADDRESS 1:

ADDRESS 2:

CITY:

STATE:

ZIP:

### Beneficiary Details

BENEFICIARY TYPE:

INDIVIDUAL  TRUST  CHARITY/ORGANIZATION

\*DATE OF TRUST:

\*NAME OF TRUST:

ADDRESS 1:

ADDRESS 2:

CITY:

STATE:

ZIP:

If you select a child under 18 as a primary beneficiary, you must also add a custodian. Currently we do not have the option on Benefit Bridge, so you will just select the "Charity/Organization" option and enter the custodian's information there. In the "Name of Charity/Organization", you will put the custodian's name and the text "as custodian for [name of child]". You will not need to select a beneficiary option or distribution percentage for them. **Note: You must have a primary beneficiary designated in order to continue.**

NAME	RELATION	BENEFICIARY	DISTRIBUTION	OPTI
[Redacted]	SPOUSE	Primary	100 %	
[Redacted]	SPOUSE	Select one	0 %	
[Redacted] AS CUSTODIAN FOR [Redacted] UNDER THE CALIFORNIA UNIFORM TRANSFERS TO MINORS ACT TRUST	N/A	Select one	0 %	

When you have entered all of the information and selected your primary beneficiary(s), hit "Save"

PLAN	COST PER PAY PERIOD	Select you														
<p>Enrolled Plan</p> <p><b>VOYA</b> FINANCIAL</p> <p>Voya-Voluntary Term Life (5 x salary)</p> <p><b>Guaranteed Coverage: \$368,000</b></p> <table border="1"> <thead> <tr> <th>NAME</th> <th>RELATION</th> <th>COVERAGE</th> </tr> </thead> <tbody> <tr> <td>[Redacted]</td> <td>SPOUSE</td> <td>Guaranteed : \$250,000</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>NAME</th> <th>RELATION</th> <th>BENEFICIARY</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>[Redacted]</td> <td>SPOUSE</td> <td>Primary</td> <td>100 %</td> </tr> </tbody> </table> <p>Add/Change Beneficiaries and Distribution </p> <p><input type="checkbox"/> Compare</p> <p><b>VOYA</b> FINANCIAL</p> <p>VOYA-Optional Life Optional Life Option 1A ( With 18K)</p>	NAME	RELATION	COVERAGE	[Redacted]	SPOUSE	Guaranteed : \$250,000	NAME	RELATION	BENEFICIARY	%	[Redacted]	SPOUSE	Primary	100 %	<p><b>\$8.17</b> (24 deductions per year)</p> <p><input type="button" value="Clear"/></p> <p><input type="button" value="Change"/></p>	<p><input type="button" value="Select you"/></p> <p><input type="button" value="Emj"/></p> <p><input type="button" value="ALV"/></p> <p><input type="button" value="SPD"/></p>
NAME	RELATION	COVERAGE														
[Redacted]	SPOUSE	Guaranteed : \$250,000														
NAME	RELATION	BENEFICIARY	%													
[Redacted]	SPOUSE	Primary	100 %													
<p><input type="checkbox"/> Compare</p> <p><b>VOYA</b> FINANCIAL</p> <p>VOYA-Optional Life Optional Life Option 1A ( With 18K)</p>	<p><b>\$0.00</b> (24 deductions per year)</p> <p><input type="button" value="Select"/></p>															

Your beneficiary will now display under your Voluntary Term Life. Press "Continue."

You will then be brought to the Group Term Life page.



### Open Enrollment

- EMPLOYEE ✓
- DEPENDENTS ✓
- VOLUNTARY TERM LIFE ✓
- GROUP TERM LIFE ✓**
- CRITICAL ILLNESS
- SUMMARY

\* Required Enrollment

✓ Selection Completed

**Plans Selected**  
(2 of 3)

Sub Total:  
**\$8.17** / PAY PERIOD

2021-BG80-TIRB

### Last Year You Chose

PLAN	COST PER PAY PERIOD	
<input type="checkbox"/> Compare		
Prudential Basic Life-\$18K	<b>\$0.00</b> (24 deductions per year)	
COVERED	RELATION	COVERAGE
EDUWIGES ALVAREZ-JIMENEZ	EMPLOYEE	\$18,000

### This Year's Coverage Options

• Basic Group Life is paid for by the County. If plan is not selected below, make your selection, then select **Continue**.

Hide ▲

PLAN	COST PER PAY PERIOD
<input checked="" type="checkbox"/> <b>Enrolled Plan</b>	<b>\$0.00</b> (24 deductions per year)
<input type="checkbox"/> Compare	
VOYA VOYA-Basic Life \$18K	<b>Clear</b> <b>Change</b>
<b>Coverage: \$18,000</b>	

Add/Change Beneficiaries and Distribution



Cancel

Continue

To make add or make changes to your beneficiaries , you will want to hit the "+" button. Once you have updated your beneficiaries, hit, "Continue."

The Group Term coverage will now display your beneficiaries.

PLAN	COST PER PAY PERIOD		
<b>Enrolled Plan</b> <input type="checkbox"/> Compare  VOYA-Basic Life \$18K	<b>\$0.00</b> (24 deductions per year)  <input type="button" value="Clear"/> <input type="button" value="Change"/>		
<b>Coverage: \$18,000</b>			
NAME	RELATION	BENEFICIARY	%
[REDACTED]	SPOUSE	Primary	100 %
<input type="button" value="Add/Change Beneficiaries and Distribution"/>			<input type="button" value="+"/>

Hit "Continue."

You will then be brought to the Critical Illness page. There are no beneficiaries to assign for Critical Illness so all you will do is hit, "Continue."



### Open Enrollment

- EMPLOYEE ✓
- DEPENDENTS ✓
- VOLUNTARY TERM LIFE ✓
- GROUP TERM LIFE ✓
- CRITICAL ILLNESS ✓**
- SUMMARY

\* Required Enrollment  
✓ Selection Completed

#### Plans Selected (3 of 3)

Sub Total:  
**\$8.87** / PAY PERIOD

2021-BG80-TIRB

#### This Year's Coverage Options

By electing coverage under the VOYA plan, you agree that you have major medical coverage for you and any dependents you are selecting coverage for.

This Critical Illness coverage is not comprehensive health insurance coverage ("major medical coverage").

To be eligible for the basic or supplemental life insurance coverage or critical illness coverage, your dependent children must be:

- Under age 26;
- Unmarried
- Not in a domestic partnership or civil union that is recognized as equivalent to marriage in the state with governing jurisdiction.

This voluntary plan provides tax-free lump sum payments upon the occurrence of certain illnesses and can provide critical financial assistance when dealing with medical related issues and absences. Some categories of coverage have also been improved and Active at Work and home/hospital confinement rules apply before coverage increases can go into effect.

Hide ▲

PLAN	COST PER PAY PERIOD	Select you
Enrolled Plan <b>VOYA</b> FINANCIAL VOYA-Critical Illness	<b>\$0.70</b> (24 deductions per year)	Emp ALV. SPOT
	Clear	
	Change	

Coverage: **\$10,000**

Cancel

Continue

# REVIEW & FINAL APPROVAL

You are almost finished! Scroll through and review the Acknowledgement provisions.

Carefully read the Information. **This is your opportunity to ensure the elections you made accurately reflect your intentions.** Any submitted enrollment will be considered reviewed and approved by the employee.

**Open Enrollment**

- EMPLOYEE ✓
- DEPENDENTS ✓
- VOLUNTARY TERM LIFE ✓
- GROUP TERM LIFE ✓
- CRITICAL ILLNESS ✓
- SUMMARY**

### SUMMARY

**Effective date of new plans:**  
04/01/2021

All plans have a pending status until all documents and information have been approved by your employer. You will receive a confirmation email when your elections have been approved.



● Employer Pays: **\$0.41** / PAY PERIOD  
● Employee Pays: **\$9.80** / PAY PERIOD

[Add Document](#)

### Plans Selected (2 of 3)

PLAN	COVERAGE FOR	COST PER PAY PERIOD
<b>Voluntary Term Life</b>		
 Voya-Voluntary Term Life (6 x salary) Coverage: \$350,000 <a href="#">Change</a>   <a href="#">Details</a>		You Pay: <b>\$9.80</b>
<b>Group Term Life</b>		
 VOYA-Basic Life \$18K Coverage: \$18,000 <a href="#">Change</a>   <a href="#">Details</a>		Employer Pays: <b>\$0.41</b> You Pay: <b>\$0.00</b>
<b>Total per pay period -</b>		Employer Pays: <b>\$0.41</b> You Pay: <b>\$9.80</b>

Cancel

Continue

Once you have had a chance to review everything and it is correct, hit the "Continue" button.

You'll then be taken to the final summary page. If the selections reflect the coverage you want, **type in your name, check the "Your Approval: I AGREE" box, and then click "Submit"**.

WELCOME EMPLOYEE TEST
Home | Logout | Need Help?

**COUNTY OF SACRAMENTO**  
 Active Employees

ALL PLANS | MESSAGE CENTER | MY BENEFITS | MY PROFILE | MORE >

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**COUNTY OF SACRAMENTO-ACTIVE**  
 Summary of Benefits for the Requested Effective Date of 1/1/2018

**MY DIGITAL SIGNATURE**

Please review all of the information on this page and when you are satisfied with your selections, check the **I Agree** box and select **Submit**.

**Acknowledgment:**  
 I hereby certify that all the information entered is true and correct to the best of my knowledge. I also understand that any false information entered will make this enrollment process and the coverage for which it applies null and void. The Plan reserves the right to rescind coverage should the information prove to be incomplete or inaccurate. I understand that my benefit elections will be in effect until the next Open Enrollment period, unless my family status changes (e.g. loss of coverage for me or my dependents, change in marital status, change in spouse/domestic partner's employment status). I understand that I must notify my employer within 30 days if I experience a qualifying event. I authorize my employer to make all payroll deductions associated with my elections. I understand that I am entitled to a copy of the plan documents for the benefit plans. Your request has been submitted. If you added dependents or waived medical coverage, your enrollment is pending receipt of those documents; the deadline for documents is 7 days from submitting these elections. An email from noreply-sacounty@keen.com will be sent to the email address listed in your Personal Information when your request is approved/denied.

**TO PRINT SUMMARY OF BENEFITS**  
 Once your enrollment has been submitted, you will be able to download a copy of your Summary of Benefits. A copy of your Summary of Benefits will also be stored in your Message Center.

**PERSONAL INFORMATION SUMMARY**

Name: EMPLOYEE TEST	Gender: Male	Date of Birth: 3/31/1963	SSN: **-**-7807
Address: 4711 POWDER COURT 11K GROVE CA 95758	Phone:	Email: etest@gmail.com	Age: 54

ETIN: 1004630

**MY DEPENDENTS SUMMARY**

DEPENDENT	RELATION	DOB	AGE	SSN	ADDRESS
SPOUSE TEST	SPOUSE	12/11/1963	53	**-0000	SAME
CHILD TEST	CHILD	7/20/1994	23	**-0000	SAME

**CORE BENEFITS SUMMARY**

**BENEFIT DETAILS** COST PER PAY PERIOD

Medical: Kaiser Permanente High Deductible-Tier A \$0.00

Coverage: Employee Carrier: KAISER PERMANENTE

COVERED	RELATION
EMPLOYEE TEST	EMPLOYEE

**Dental: Delta Dental-Active** \$0.00

Coverage: Employee + One Plus Carrier: DELTA DENTAL OF CALIFORNIA

COVERED	RELATION
EMPLOYEE TEST	EMPLOYEE
SPOUSE TEST	SPOUSE
CHILD TEST	CHILD

**Voluntary Term Life: Optional Life-Option 3** \$30.91

Coverage: \$273,000 Carrier: PRUDENTIAL

COVERED	RELATION	GUARANTEED COVERAGE	REQUESTED COVERAGE
EMPLOYEE TEST	EMPLOYEE	\$273,000	
SPOUSE TEST	SPOUSE	\$30,000	

**Group Term Life: Basic Life-\$18K** \$0.00

Coverage: \$18,000 Carrier: PRUDENTIAL

COVERED	RELATION	GUARANTEED COVERAGE
EMPLOYEE TEST	EMPLOYEE	\$18,000

**Health Savings Account: HSA Kaiser Active** Per Pay Period: \$2,500 \$104.17

Carrier: County

**BENEFIT DETAILS**

**Flexible Spending Account: County FSA 2018** Annual Medical: \$2,000 \$83.33

Carrier: Flex Plan Services

\*Cost Summary

\*Note: Actual deductions may vary slightly due to rounding

	PER PAYCHECK (24 DEDUCTIONS)	ANNUAL AMOUNT
Flexible Spending	\$83.33 (24 Deductions)	\$2,000.00
HSA	\$104.17 (24 Deductions)	\$2,500.00
Employee pays	\$30.91	\$741.72
Employer pays	\$359.08	\$8,617.80
Total Benefits Cost	\$389.99	\$9,359.52

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

**For employees selecting the Kaiser Permanente health care plan**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

By selecting the **I Agree** checkbox below, I understand that this action will serve as my electronic signature of agreement to the conditions provided in the **Kaiser Foundation Health Plan Arbitration Agreement** (above) and that by law this electronic signature will have the same effect as a signature on a paper form.

Note: If you do not wish to accept the arbitration agreement above, select Cancel and return to the "Medical" enrollment page to make a new Health Plan selection.

\*NAME:

**Your Approval: I AGREE** (Check to confirm your final approval.)

Cancel
Submit

**Important Reminder: Your enrollment request is not complete until you get to the Summary tab at the end of your enrollment, check the "Your Approval: I agree" box and click the "SUBMIT" button to complete your Open Enrollment request. All Changes will take effect immediately.**