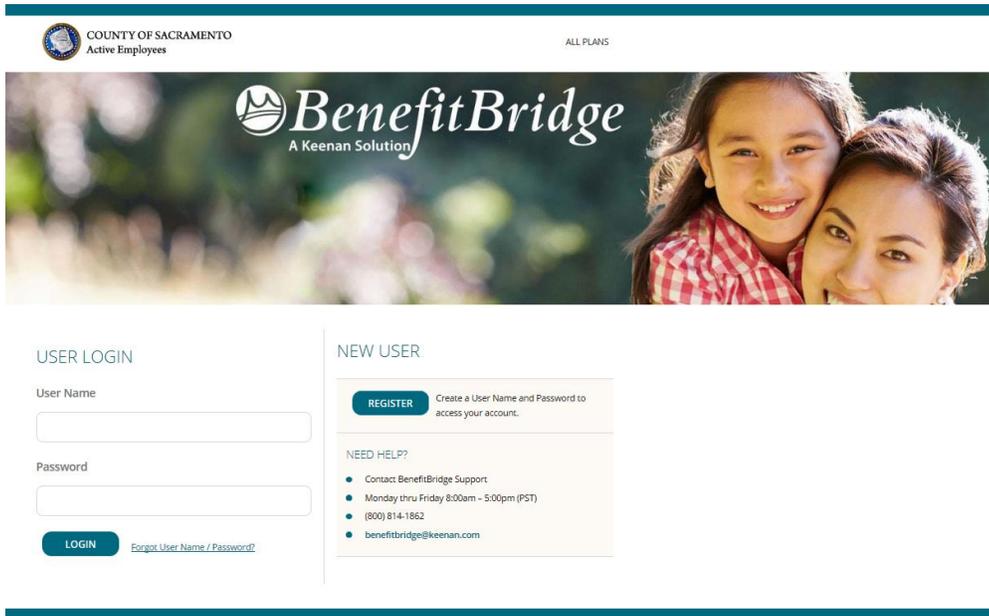




# Making Changes to your Life Insurance

These instructions will help you navigate through BenefitBridge in making your changes to your Life Insurance or Critical Illness coverage.



For coverage effective in

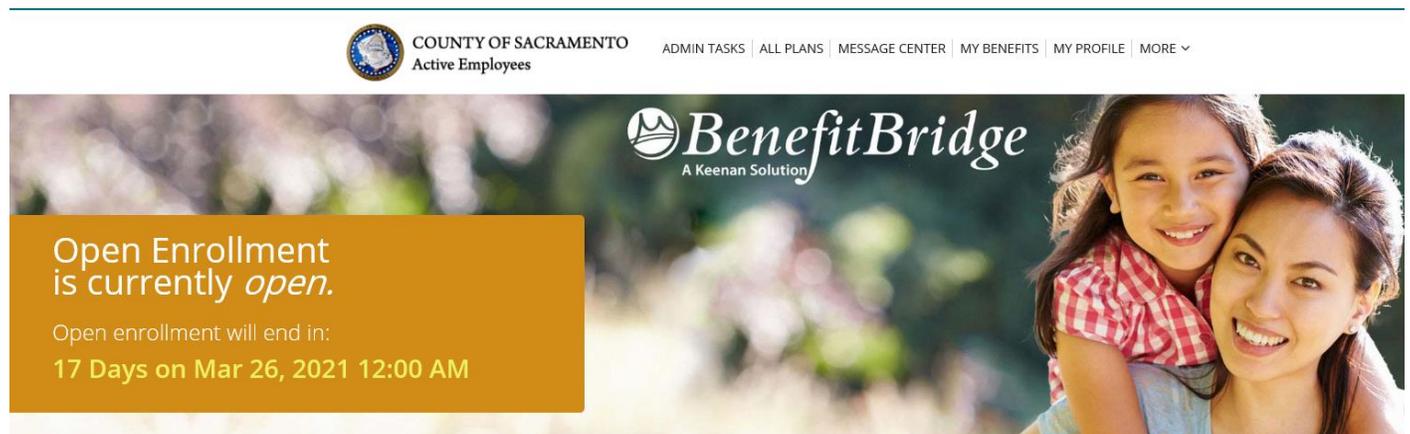
# April 2021

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

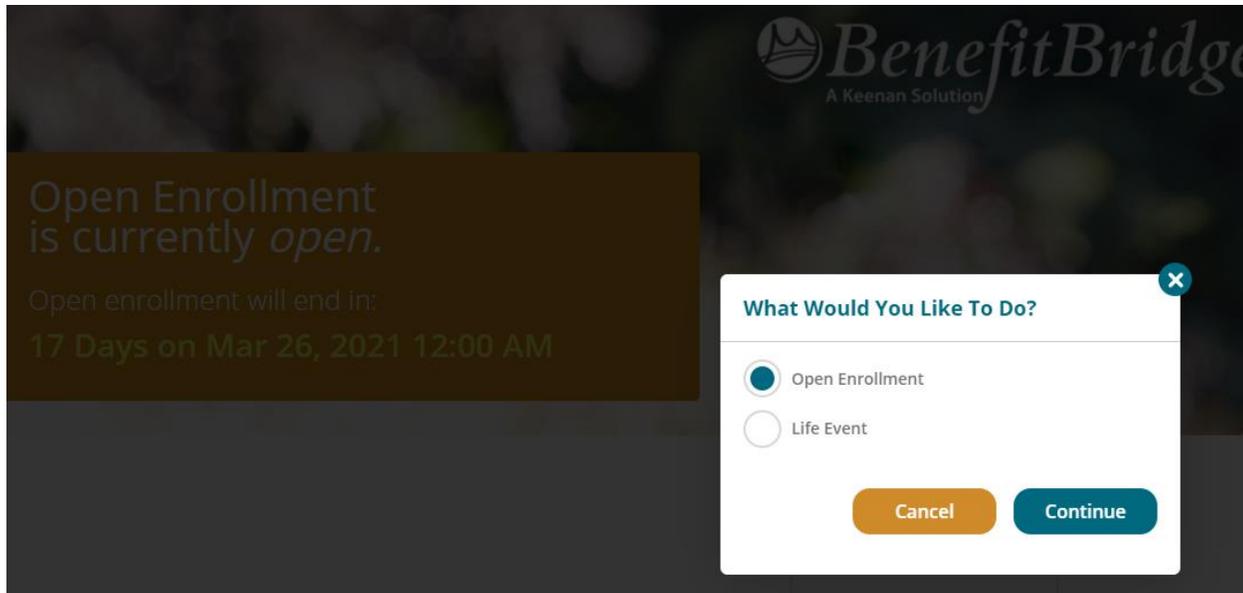
**Please log on using your User Name and Password. If you have forgot your user name and password, please click on the link next to the LOGIN button.**



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" value=""/>	** -0000	SPOUSE	48	Select ▾

Please provide documentation if required by your Employer

Add Document

Cancel

Continue

**NOTE: You must add a spouse/domestic partner or children here in order to be able to enroll them. If they are not listed here, you will not be able to add coverage to them. You do need to provide documentation to complete enrollment or coverage. You do *not* need to provide documentation if only listing them as a beneficiary.**

Once you are done, hit continue.

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

**Open Enrollment**

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

*\* Required Enrollment*  
✓ Selection Completed

**Plans Selected**  
(1 of 3)  
Sub Total:  
**\$0.00** / PAY PERIOD

2021-BG80-TIRB

### 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.

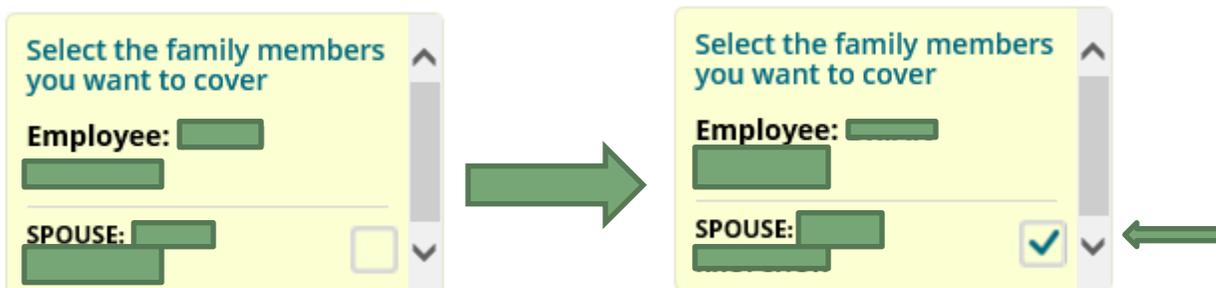
This coverage would pay the beneficiary(ies) tax-free money in the event of death. The dependent life coverage would pay you the loss of a Spouse/Domestic Partner/Dependent.

Hide ^

PLAN	COST PER PAY PERIOD	Select the family members you want to cover
 Voya-Voluntary Term Life (1 x salary)	<b>\$0.00</b> (24 deductions per year)	Employee: [ ] [ ] SPOUSE: [ ] <input type="checkbox"/>
 VOYA-Optional Life Optional Life Option 1A ( With 18K)	<b>\$0.00</b> (24 deductions per year)	Employee: [ ] [ ] SPOUSE: [ ] <input checked="" type="checkbox"/>

Cancel Continue

To make changes, you will want to hit the "select" button near the option you want to change. If you are making a change for a dependent as well, please make sure their name is checked in the yellow box on the right side of the screen.



For more information on the different options, please refer to the Voya website <https://presents.voya.com/EBRC/saccounty> or contact the Employee Benefits Office. Once you hit "select", a new window will pop up for you to make changes.

**Edit Coverage Amount**

- If you elect to enroll in or make changes to Voluntary Term Life coverage, please select the Benefit Amount for Employee and Dependents, if applicable

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.

Need help estimating an appropriate amount of coverage? Click on the following link for a helpful calculator:

[Life Insurance Calculator](#)

EMPLOYEE COVERAGE:

Select 

Applicable Coverage:

VOYA-Optional Life Optional Life  
Option 1A ( With 18K)

Click on the drop down menu to select the amount of coverage you want. If you are making changes to a dependent, you will not be able to make changes until your insurance is selected.

Once you are done, hit continue.

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 %	

[Add Beneficiary](#) [Cancel](#) [Save](#)

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

**If you have selected an amount greater than the guaranteed amount, you will have to go through the Evidence of Insurability questionnaire.**

**Evidence of Insurability**

**EVIDENCE OF INSURABILITY**

YOU HAVE ELECTED AN AMOUNT OF COVERAGE WHICH REQUIRES EVIDENCE OF INSURABILITY. IN ORDER TO RECEIVE THE COVERAGE AT THIS LEVEL, YOU MUST ANSWER A FEW ADDITIONAL QUESTIONS.

- YOU WILL BE REDIRECTED TO A VOYA LIFE INSURANCE WEBSITE.
- YOUR ANSWERS WILL NOT BE VISIBLE TO ANYONE OUTSIDE OF VOYA INCLUDING YOUR EMPLOYER.
- AT THE CONCLUSION OF THIS QUESTIONNAIRE YOU WILL BE APPROVED OR YOUR RESPONSE MAY BE FORWARDED TO VOYA UNDERWRITING FOR FURTHER REVIEW.

**Cancel** **I Agree**

PER PAY PERIOD  
**\$0.00**  
ductions per ye  
select

**\$0.00**  
ductions per ye  
select

**Hit the “I Agree” button, and you will be taken to the Voya questionnaire:**

**1 Employee**  
Fill your employee details

**2 Coverage**  
Choose your coverages

**3 Questions**  
Answer health questions

**4 Summary**  
Confirm and sign

### Step 1: Employee Information

\* Indicates required field

First Name\* :

Middle Initial :

Last Name\* :

Date of Birth\* :  /  / 19

Social Security Number\* :  -  -

Gender\* :  Male  Female

Country\* : UNITED STATES

Address Line 1\* :

Address Line 2 :

City\* : SACRAMENTO

State/Province\* : CA

Zip/Postal Code\* :

Home Phone Number\* : 916 -  -

Cell Phone Number\* :  -  -

Email Address\* :   
*This email address will be used for all electronic communications.*

Job Title :

Employee ID :

Annual Salary :  \*\*\*\*\*.00

Hire Date (Full-time) : 01 / 02 / 20

Save

Next

It will be pre-populated with your information. Just verify the information and then hit the "next" button.

The next screen will then show the amount you are requesting.

## My Evidence of Insurability

- 1 Employee**  
Fill your employee details
- 2 Coverage**  
Choose your coverages
- 3 Questions**  
Answer health questions
- 4 Summary**  
Confirm and sign

### Step 2: Coverage Information

Please Complete/review the fields below for your elected coverages.

Employee Coverage	Total Amount Desired	- Current Amount	- Guaranteed Issue Amount	= Amount to be Underwritten
<input checked="" type="checkbox"/> Supplemental Life	\$ 421,000.00	\$ 350,000.00	\$ 0.00	\$ 71,000.00
Spouse	Total Amount Desired	- Current Amount	- Guaranteed Issue Amount	= Amount to be Underwritten
<input type="checkbox"/> Supplemental Life				

Save

Previous

Next

Verify this amount and then hit the "next" button.

You will be then taken to the questionnaire.

Primary Health Practitioner (PHP):

Name	Phone	Street Address	City	State	Zip	No PHP
<input type="text"/>	<input type="checkbox"/>					

EMPLOYEE HEALTH QUESTIONS

Employee (EE)

*Must be answered for coverage that is not Guaranteed Issue.*

1. Within the last 5 years have you been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)?  Yes  No
2. Within the last 5 years have you been treated for, any of the following: Insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?  Yes  No
3. Employee: Height  ft.  in. Weight  lbs.
4. In the past 5 years have you been diagnosed or treated by a health practitioner, or taken medication for any of the following:
  - a. Any disease or abnormality of the heart or blood vessels (excluding controlled high blood pressure), or any heart rhythm abnormality?  Yes  No
  - b. Any disease of the lung (excluding asthma), liver (excluding hepatitis A), pancreas or intestine?  Yes  No
  - c. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?  Yes  No
  - d. Cancer or tumor, rheumatoid arthritis, connective tissue disease, neurological disease (excluding headaches), autoimmune disease or any disease of the blood cells or serum including, but not limited to, anemia, polycythemia, or bleeding or clotting disorder?  Yes  No
  - e. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?  Yes  No
  - f. Polycystic kidney disease or kidney failure?  Yes  No
5. Within the last 5 years have you been diagnosed or treated by a physician or other health practitioner for:
  - a. Chest pain, heart trouble or circulatory disorder?  Yes  No
  - b. Anemia or leukemia?  Yes  No
  - c. Sleep apnea, asthma or other respiratory disease?  Yes  No
  - d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disease?  Yes  No
  - e. Stomach disease?  Yes  No
  - f. Brain or seizure disorder?  Yes  No
  - g. Mental or nervous disorder?  Yes  No
  - h. Arthritis, paralysis or any muscle weakness impacting your ability to perform daily activities?  Yes  No
  - i. Abnormal urine specimen or urinary tract disorder?  Yes  No
  - j. Prostate or other reproductive organ disorder?  Yes  No
6. Are you pregnant? Due Date  Pre-pregnancy weight  lbs.  Yes  No
7. Are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, or disease not shown above?  Yes  No
8. Within the last 5 years have you received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?  Yes  No

Save

Previous

Next

Answer the questions and then hit the "next" button. You will then be taken to the summary page, and you will need to scroll down.

**1 Employee**  
Fill your employee details

**2 Coverage**  
Choose your coverages

**3 Questions**  
Answer health questions

**4 Summary**  
Confirm and sign

## Step 4: Summary

### Instructions

Please read and review the information captured on the following Evidence of Insurability (EOI) application(s). Once you have confirmed that all of the information is complete and true to the best of your knowledge and belief, please provide your signature in the Employee Signature section.

After submitting, you will have the ability to select a method by which you would like to receive a completed copy of your EOI application(s) for your records.

**Note:** if you need to make any changes to your information, please return to the appropriate screen and update your information prior to signing and submitting your EOI application(s). Once you have signed and submitted your EOI application(s), you will not be able to make changes in the system.

### Read and Review Evidence of Insurability Application

#### ELECTRONIC SIGNATURE PROCEDURES AND SECURITY MEASURES

ReliaStar Life Insurance Company, Minneapolis, MN  
ReliaStar Life Insurance Company of New York, Woodbury, NY  
*Members of the Voya family of companies*

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York use electronic signatures to expedite the submission process. These procedures are provided for your review so you may better understand the use of electronic signatures and the protections provided.

#### ELECTRONIC SIGNATURE

Once you have completed the form you will be prompted to enter your signature. Your signature is captured by entering your password to gain access to complete the form, and then after reviewing the information contained on the form and a message alerting you to the effect of your signature, clicking on the "I Accept" box displayed on the screen.

165529

Page 1 of 1

Order #165529 09/01/2014

I Agree

Yes, I have reviewed and understand all of the documents provided to me and agree to be bound by all of the terms and conditions therein.

Save

Previous

Click on the "I Agree" check box.

<input checked="" type="checkbox"/> I Agree	Yes, I have reviewed and understand all of the documents provided to me and agree to be bound by all of the terms and conditions therein.
<input type="checkbox"/> I Accept	By checking this box and clicking Submit (1) I understand that my electronic signature will be applied to all documents requiring my signature and (2) I declare that all information provided by me is complete and true to the best of my knowledge and belief.
<input type="button" value="Save"/>	<input type="button" value="Previous"/>

You will then click on the “I Accept” box.

<input checked="" type="checkbox"/> I Agree	Yes, I have reviewed and understand all of the documents provided to me and agree to be bound by all of the terms and conditions therein.
<input checked="" type="checkbox"/> I Accept	By checking this box and clicking Submit (1) I understand that my electronic signature will be applied to all documents requiring my signature and (2) I declare that all information provided by me is complete and true to the best of my knowledge and belief.
<input type="button" value="Previous"/>	<input type="button" value="Submit"/>

Once you’ve done that, you’ll have the option to submit your questionnaire. Hit “Submit”

**You will be taken to a screen where you can get a copy of the questionnaire you just filled out. Once you've gotten a copy (if you want one), hit "Next".**

PLAN | INVEST | PROTECT

## My Evidence of Insurability

**A Copy of your Completed Evidence of Insurability Application(s) is now Available!**

Please choose from the options below to retain a copy of your completed Evidence of Insurability application(s) for your records, then click on the "Next" button to continue to the confirmation page:

Print

Save

Mail a copy

**Please click the Next button to review the status of your submitted EOI Application(s).**

Please Note: You will be notified via postal mail of the final decision. Please save that notice with your submitted EOI for your records.

Next

**The last screen will let you know if you are approved, or if more information is needed. Once you have reviewed this screen, hit "Finish".**

## My Evidence of Insurability

### Confirmation and Status

Coverage	Proposed Insured	Underwritten Amount	Decision
Employee Supplemental Life		\$71,000	Approved

A Final Action Notice detailing this decision will be mailed to the address you provided.

Reference Number: 3658277

**ALL LIFE INSURANCE COVERAGE IS SUBJECT TO YOUR EMPLOYER'S BENEFIT PLAN LIMITS.** The amount of coverage we may approve and the amount of coverage your employer determines you are eligible for may not be the same. If your life insurance coverage is limited by your employer's benefit plan, the death benefit under your policy (including any refund of premiums) will be adjusted at the time of claim payment. Please contact your employer for specific details regarding your employer's benefit plan limits.

**PLEASE NOTE THAT APPROVED LIFE INSURANCE COVERAGE IS NOT EFFECTIVE IMMEDIATELY.** The effective date of your coverage is determined by your employer's benefit plan and the group contract. The Company will have no liability for any claim on account of death occurring prior to the effective date of coverage. Please contact your employer for specific details regarding your coverage effective date.

Questions regarding the decisions communicated can be submitted to Voya Medical Underwriting at P.O. Box 20, Route 7812, Minneapolis, MN 55440-9978 or call 1-800-537-5024, option 4.

[Finish](#)

You will then be notified your logout is complete. Hit the "Finish Questionnaire" button in the top right corner.

[Finish Questionnaire](#)



## My Evidence of Insurability

Logout Complete

You may close this browser tab or window now

### Contact Us

Contact us at (800) 748-4444 for questions or require assistance.

### Instructions

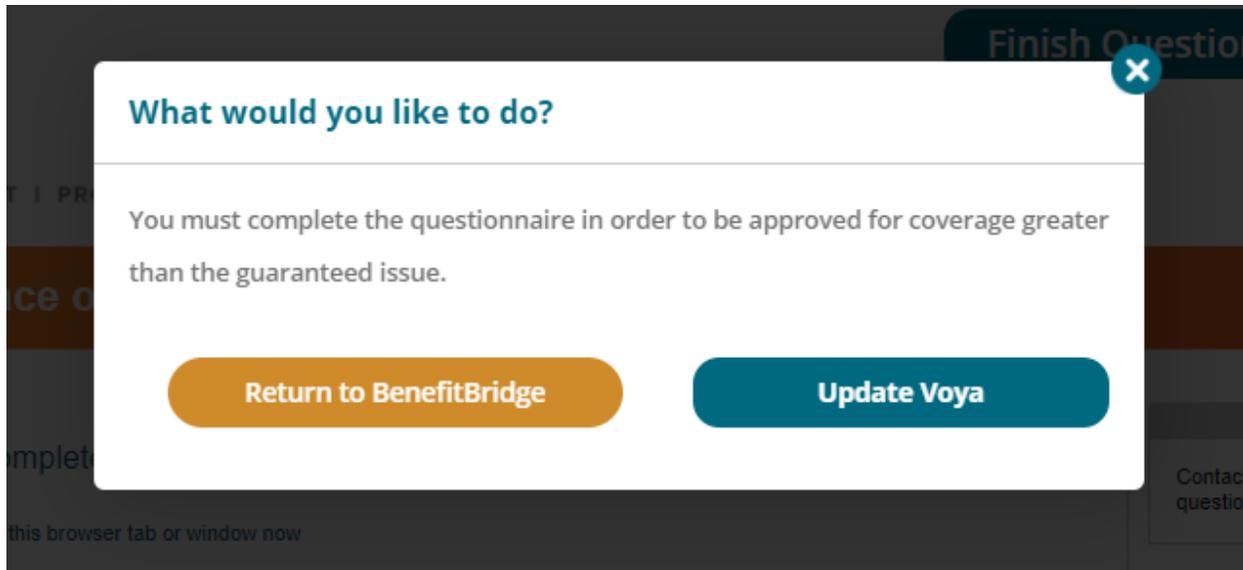
To get started, choose the "Finish Questionnaire" button in the status column.

Note: You will be returned to the home page after your submission.

### General Information

Note: For your protection, this session will be terminated automatically for a period of 15 minutes.

A pop up window will ask if you want to return to BenefitBridge. Select this option.



You will then be returned to the Voluntary Life Insurance page, with all of the information updated.

**NOTE: If you are insuring a Spouse/Domestic Partner for more than the guaranteed amount, they will have to fill out their own Evidence of Insurability (EOI) questionnaire. Once you have submitted your request for coverage, a separate email will be sent to you containing the link to the Spouse EOI. You will need to register as a new user.**

The screen will now reflect the requested amount. Please note that the cost per pay period shown only reflects the guaranteed coverage, not the full requested amount.

PLAN	COST PER PAY PERIOD
<b>Enrolled Plan</b>  Voya-Voluntary Term Life (6 x salary)	<b>\$9.80</b> (24 deductions per year)
	<b>Clear</b>
	<b>Change</b>

Select you  
Emp  
SAM  
SPO

**Guaranteed Coverage: \$350,000**  
**Requested Coverage: \$421,000**

NAME	RELATION	BENEFICIARY	%
BRYAN KROFCHOK	SPOUSE	Primary	100 %

Add/Change Beneficiaries and Distribution **+**

 VOYA-Optional Life Optional Life Option 1A ( With 18K)	<b>\$0.00</b> (24 deductions per year)
	<b>Select</b>

**Cancel** **Continue**

**Hit continue.**

**The next screen is your basic life insurance that is provided to you by the County. Just select continue down at the bottom, as you cannot make changes to this.**

## Open Enrollment

EMPLOYEE ✓

DEPENDENTS ✓

VOLUNTARY TERM LIFE ✓

GROUP TERM LIFE ✓

CRITICAL ILLNESS

SUMMARY

\* Required Enrollment

✓ Selection Completed

### Plans Selected

(2 of 3)

Sub Total:

\$9.80 / PAY PERIOD

2021-BG80-TIRB

## Last Year You Chose

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

Cancel

Continue

You will then be taken to Critical Illness, and you can make any changes you want your election changes.



### Open Enrollment

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

\* Required Enrollment  
✓ Selection Completed

**Plans Selected**  
(2 of 3)

**Sub Total:**  
**\$9.80** / 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 v Emp SPOU
 VOYA-Critical Illness	<b>\$0.00</b> (24 deductions per year)	
	<a href="#">Select</a>	

[Cancel](#) [Continue](#)

The process will be the same as with the Voluntary Life Insurance.

Once you are all done, hit continue.

You're almost finished. You will now see a summary page of the changes and the costs for your life insurance.

Hit Continue one more time, and then you will be at the final summary page. Please review again for accuracy, and then continue to the bottom of the page.

**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 will 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 >

### 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 Phone: Email: etest@gmail.com Age: 54  
1016 GROVE CA 95758  
EIN: 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 \$0.00

Medical: Kaiser Permanente High Deductible-Tier A  
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.

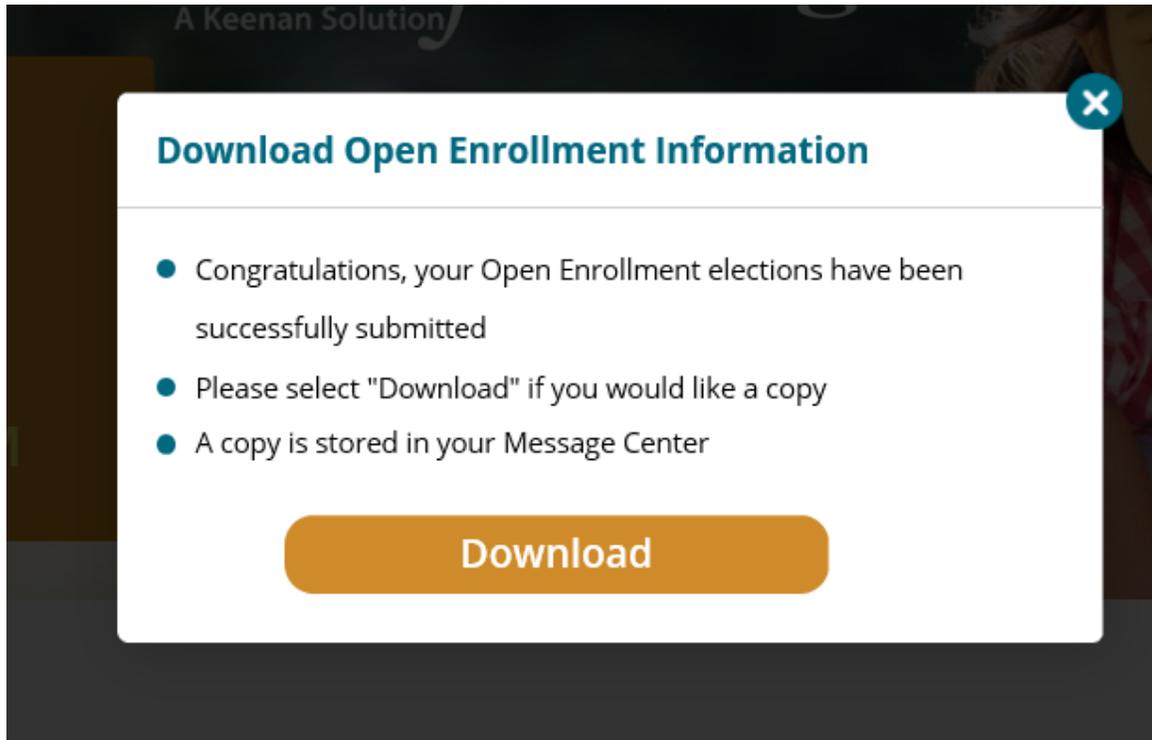
Note: If you do not wish to accept the arbitration agreement above, select Cancel and return to the "Medical" enrollment page to make a new Health Plan selection.

\*NAME:

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

**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 are irrevocable will take effect the 1<sup>st</sup> of April, 2021.**

Note: You will receive a below pop-up screen if you wish to download your submission to your beneficiary or CI/ Life changes you submitted. If you select download a copy of your submission of your changes, it will be stored in the Message Center and you now have record of your submission and can review to ensure you made all your changes for open enrollment to be effective 4/1/2021:



You can always log on later and select Message Center to review a record stored to your changes.



COUNTY OF SACRAMENTO  
Active Employees

ADMIN TASKS

ALL PLANS

MESSAGE CENTER

MY BENEFITS

MY PROFILE

MORE





## MESSAGES

 Delete

Search: <input type="text"/>			
<input type="checkbox"/> FROM	SUBJECT	DATE	ATTACHMENT
<input type="checkbox"/> SYSTEM MAIL	Open Enrollment Submitted	03/09/2021 10:55:19 AM	<a href="#">Download</a>