columbusindiana

unexpected.unforgettable.

OPEN ENROLLMENT

FOR 2021 COVERAGE

Human Resources

812-376-2570

lburns@columbus.in.gov

Open Enrollment Starts

Monday, November 2			
Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	
	Phone help	6-8 pm	812-376-2570
Tuesday, November 3			
Need enrollment assistance?	Phone help	12-6 pm	812-376-2570
Wednesday, November 4			
Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	
	Phone help	6-8 pm	812-376-2570
Thursday, November 5			
Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	
	Phone help	6-8 pm	812-376-2570
Friday, November 6			
Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	
Saturday, November 7			
Need enrollment assistance?	Phone help	12-3 pm	812-376-2570

Monday, November 9			
Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	

Tuesday, November 10			
Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	
	Phone help	6-8 pm	812-376-2570

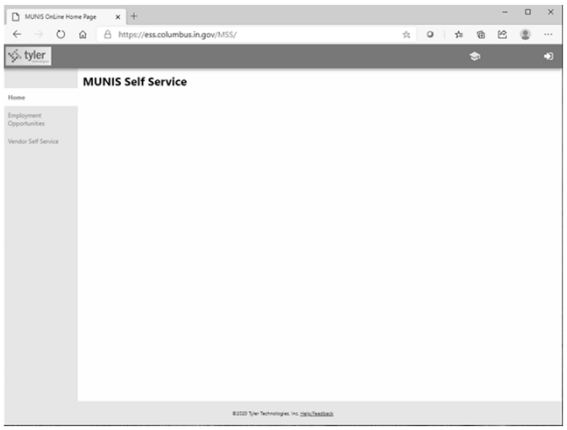
Wednesday, November 11			
Need enrollment assistance?	Phone help	12-3 pm	812-376-2570

Thursday, November 12	
Need enrollment assistance?	By appointment only - call 812-376-2570 to schedule an appointment

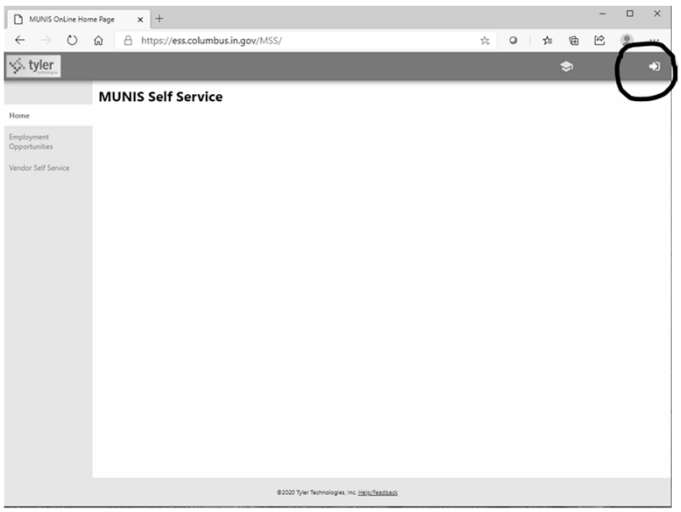
Friday, November 13			
Need enrollment assistance?	By appointment only - call 812-376-2570 to schedule an appointment		
	Phone help	6-8 pm	812-376-2570

Saturday, November 14	
Need enrollment assistance?	By appointment only - call 812-376-2570 to schedule an appointment

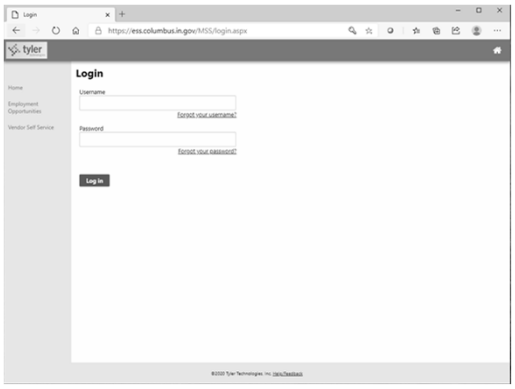
Sunday, November 15
Open enrollment closes at midnight



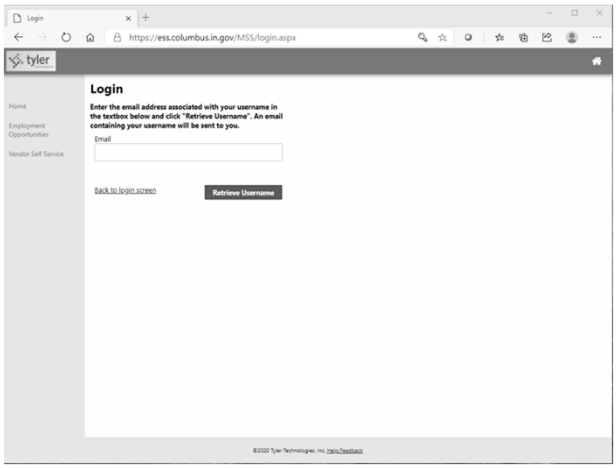
OPEN BROWSER AND GO TO
HTTPS://ESS.COLUMBUS.IN.GOV/MSS/



CLICK ON THE DOORWAY TO LOG IN



YOUR USERNAME IS YOUR EMPLOYEE ID NUMBER. IF YOU DO NOT KNOW YOUR EMPLOYEE ID NUMBER CLICK “FORGOT YOUR USERNAME?” OR CONTACT YOUR DEPARTMENT’S ADMINISTRATIVE ASSISTANT.

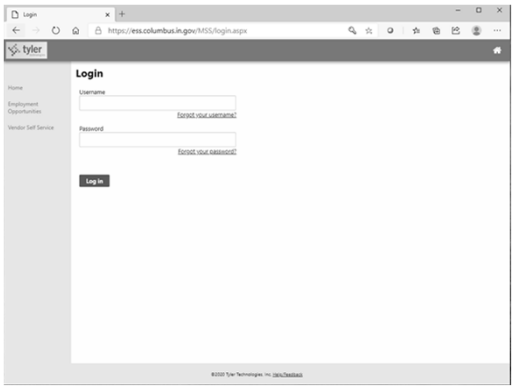


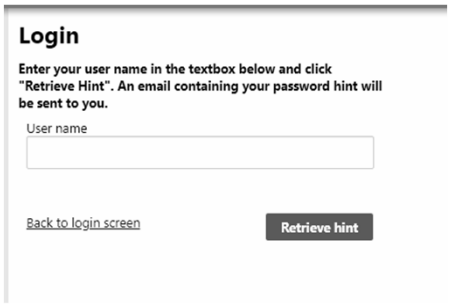
ENTER YOUR CITY EMAIL ADDRESS HERE AND CLICK RETRIEVE USERNAME

NoReply@MUNIS.com

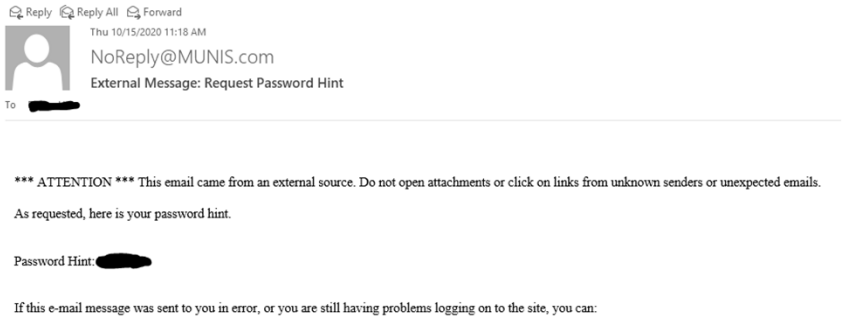
External Message: Request Forgotten Username

CHECK YOUR CITY EMAIL ACCOUNT FOR AN EMAIL LIKE THE ABOVE IMAGE.

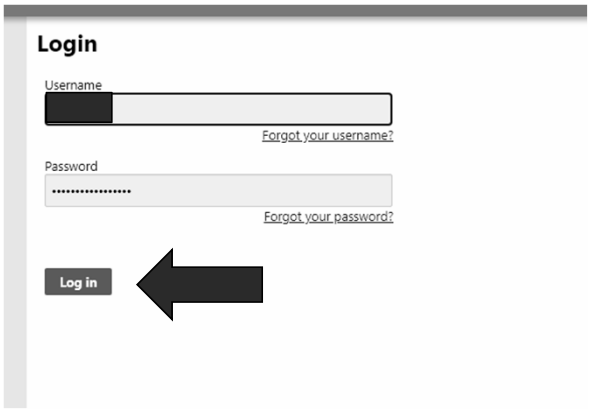




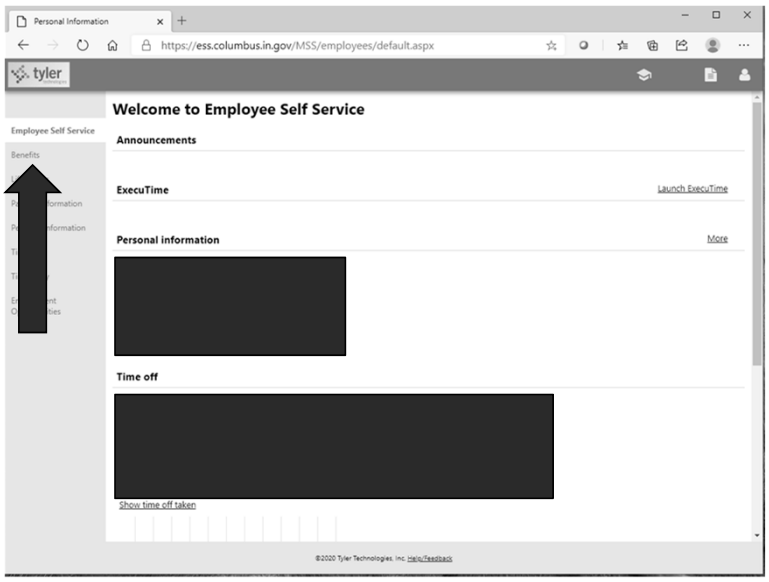
IF YOU FORGET YOUR PASSWORD CLICK "FORGOT YOUR PASSWORD?", ENTER YOUR USERNAME IN THE BOX, AND CLICK RETRIEVE HINT.



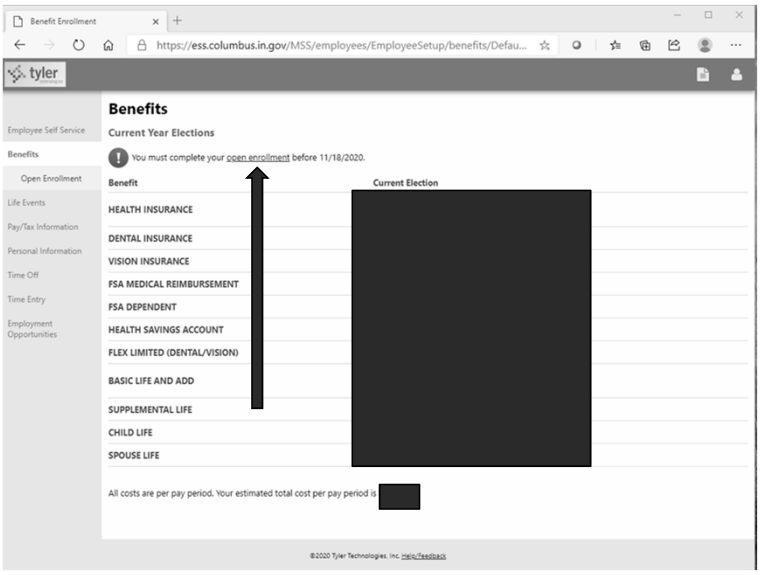
CHECK YOUR CITY EMAIL ACCOUNT FOR AN EMAIL LIKE THE ABOVE IMAGE. IF THE HINT DOESN'T GIVE YOU ENOUGH INFORMATION, CLICK THE LINK IN THE EMAIL TO RECEIVE A NEW PASSWORD. THEN CHECK YOUR EMAIL!



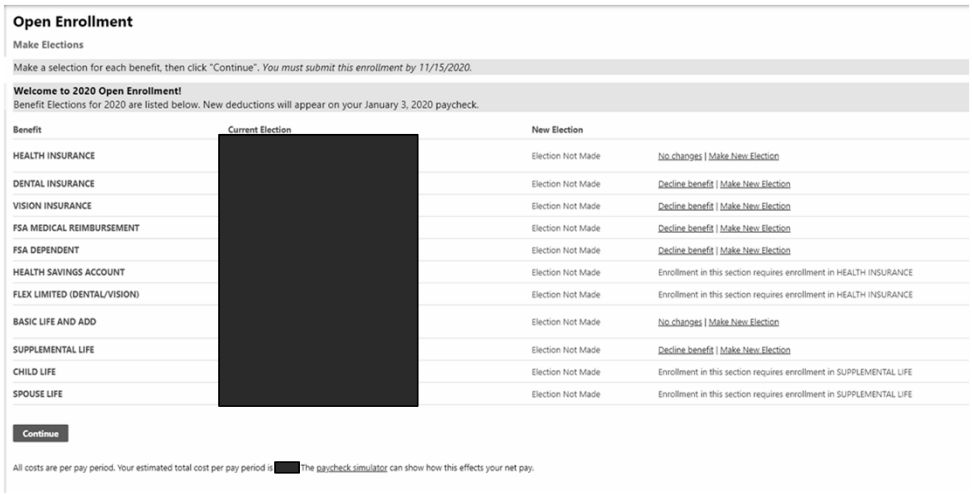
AFTER YOU HAVE ENTERED YOUR USERNAME AND PASSWORD CLICK “LOG IN”



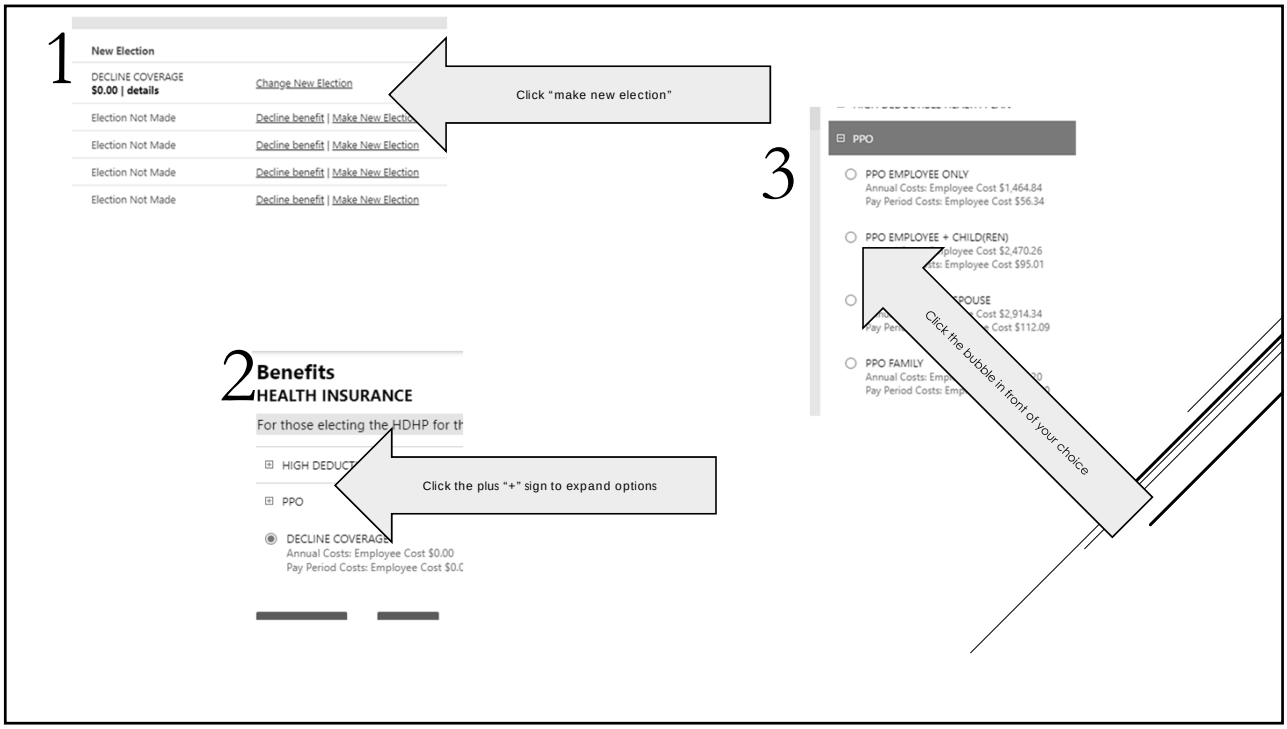
THIS IS THE MAIN PAGE. CLICK ON “BENEFITS”

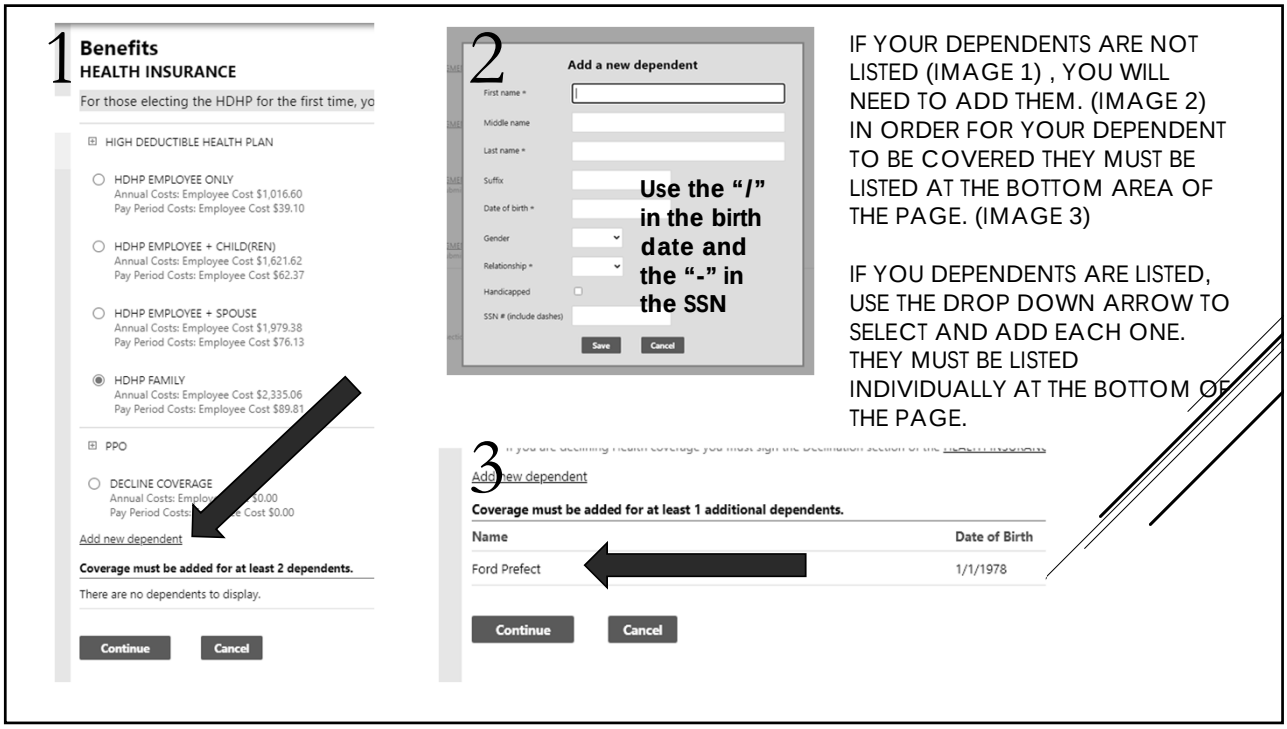


THIS PAGE SHOWS YOUR CURRENT BENEFITS. CLICK ON "OPEN ENROLLMENT" TO BEGIN ELECTING BENEFITS FOR 2021



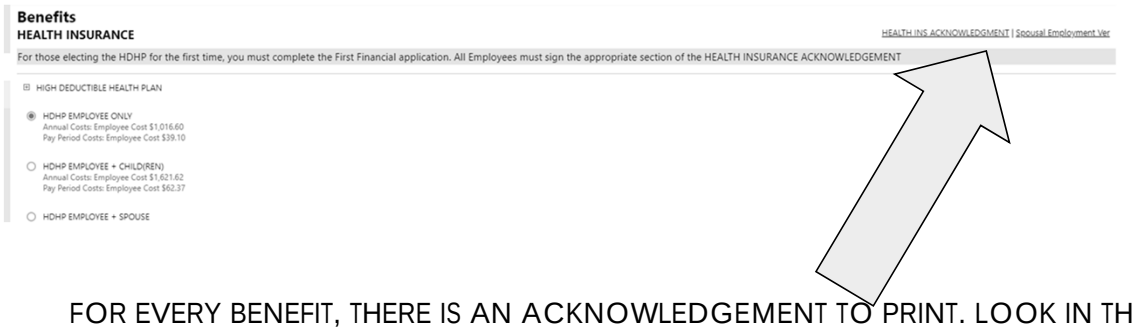
YOU HAVE THE OPTION OF ELECTING: NO CHANGES, MAKE NEW ELECTION OR DECLINE BENEFIT. YOU MUST ACTIVELY MAKE A CHOICE FOR EACH BENEFIT.





IF YOUR DEPENDENTS ARE NOT LISTED (IMAGE 1) , YOU WILL NEED TO ADD THEM. (IMAGE 2) IN ORDER FOR YOUR DEPENDENT TO BE COVERED THEY MUST BE LISTED AT THE BOTTOM AREA OF THE PAGE. (IMAGE 3)

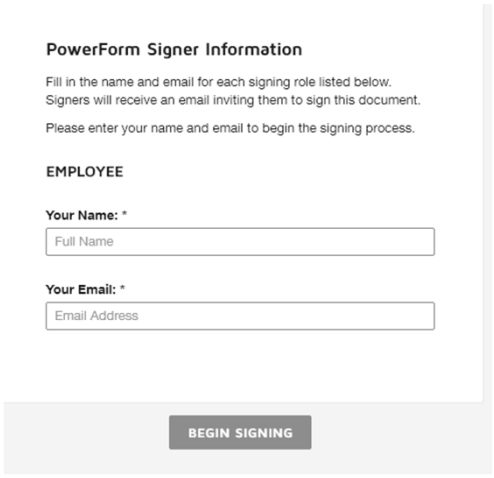
IF YOU DEPENDENTS ARE LISTED, USE THE DROP DOWN ARROW TO SELECT AND ADD EACH ONE. THEY MUST BE LISTED INDIVIDUALLY AT THE BOTTOM OF THE PAGE.



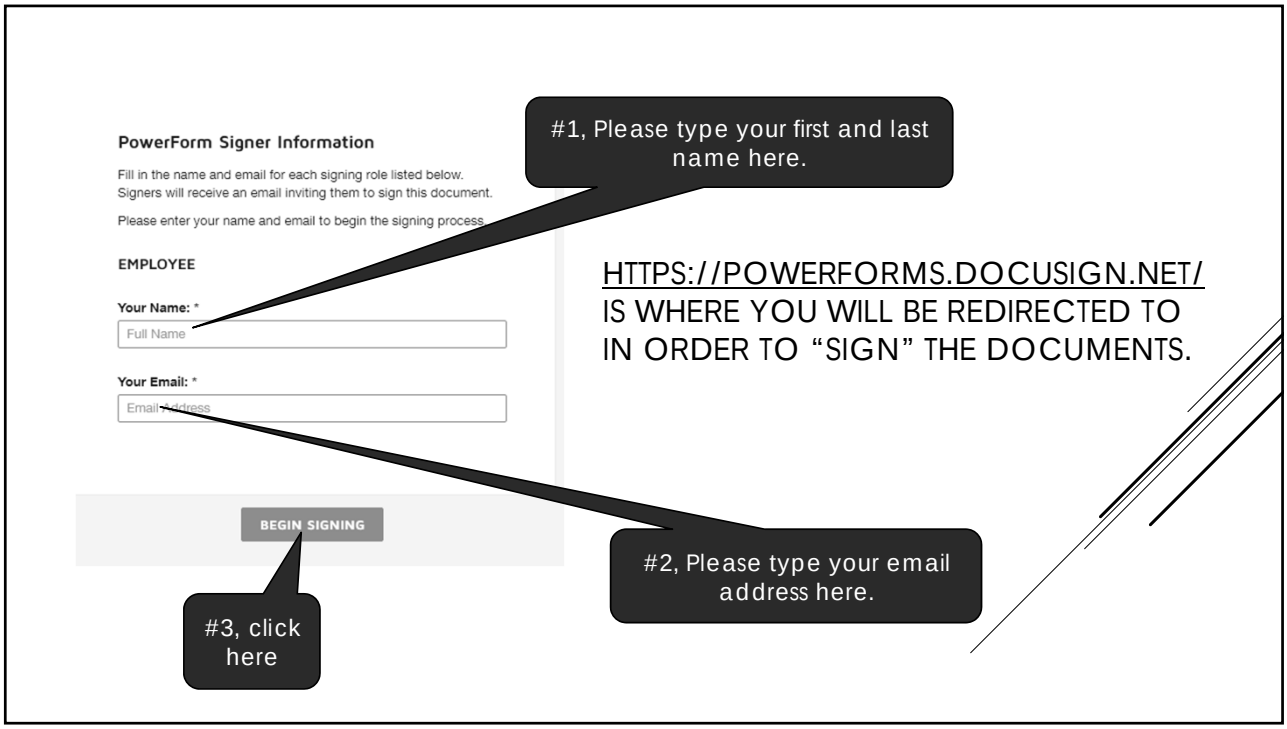
FOR EVERY BENEFIT, THERE IS AN ACKNOWLEDGEMENT TO PRINT. LOOK IN THE UPPER RIGHT HAND CORNER FOR THE BLUE LINKS.

IF YOU ARE ELECTING COVERAGE FOR A SPOUSE, MAKE SURE TO COMPLETE SPOUSAL EMPLOYMENT VERIFICATION

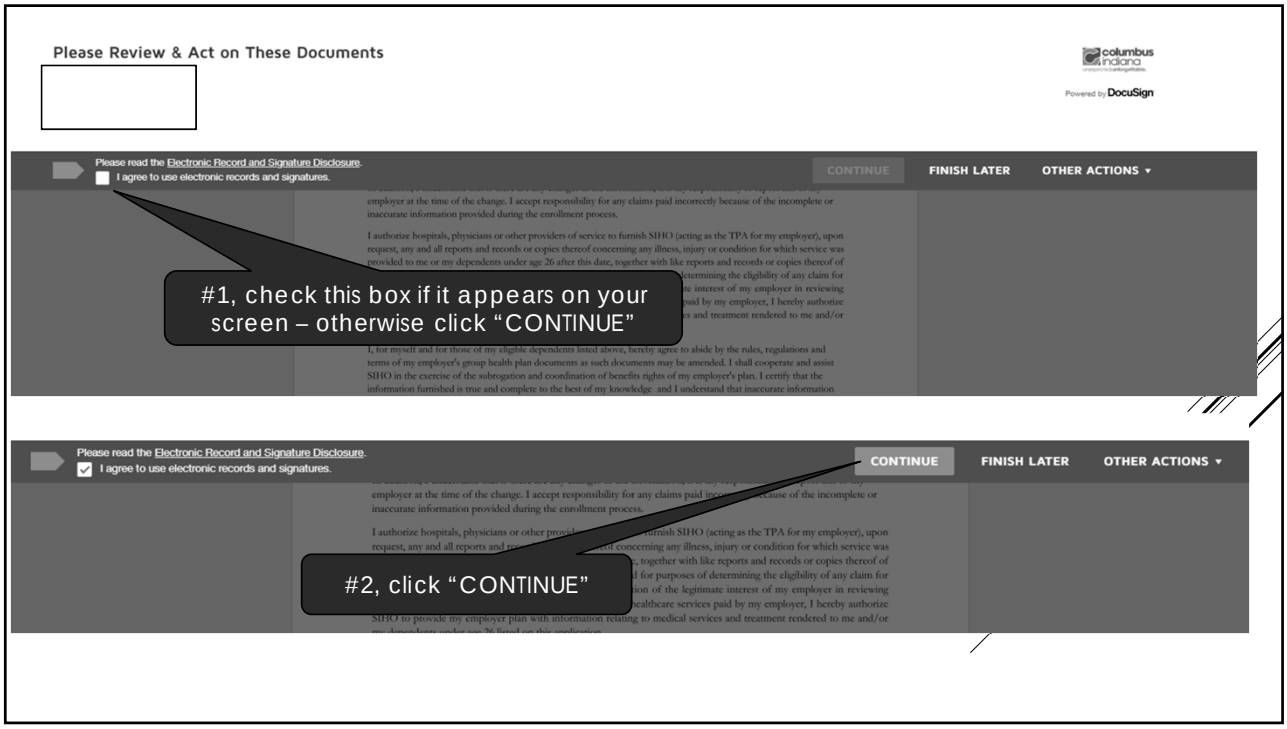
YOU WILL BE TAKEN TO A DIFFERENT WEBSITE TO SIGN THIS DOCUMENT IN DOCUSIGN.



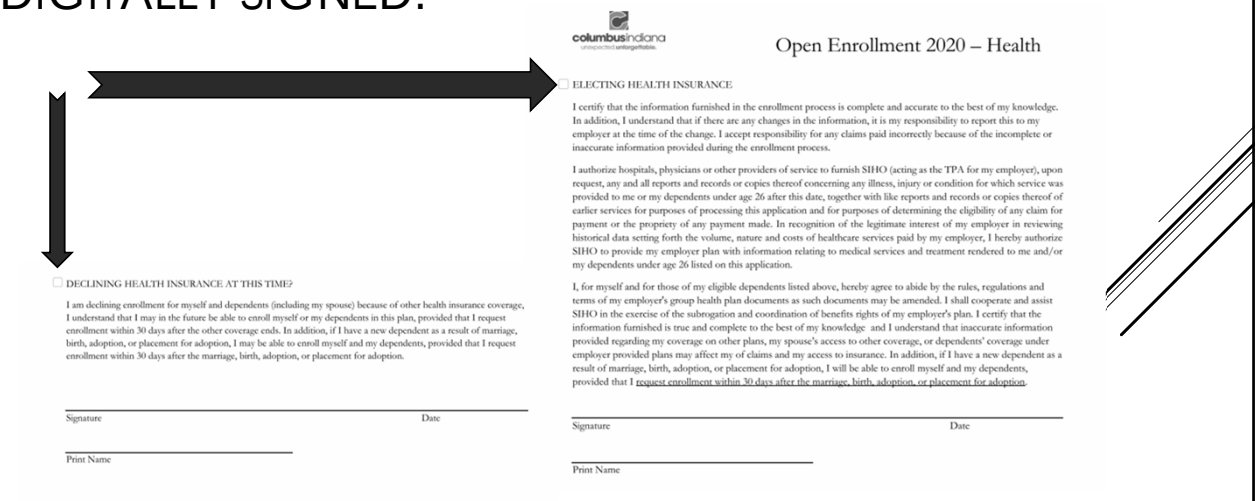
YOU WILL BE DIRECTED TO THIS SCREEN FOR EVERY COVERAGE CHOICE. PLEASE ENTER YOUR NAME AND EMAIL AND FOLLOW THE INSTRUCTIONS PROVIDED ON THE NEXT PAGES.



HTTPS://POWERFORMS.DOCUSIGN.NET/ IS WHERE YOU WILL BE REDIRECTED TO IN ORDER TO "SIGN" THE DOCUMENTS.



ALL OF THE FORMS WILL HAVE A CHECK BOX THAT MUST BE CHECKED BEFORE THE DOCUMENT CAN BE DIGITALLY SIGNED.



columbusindiana

Open Enrollment 2020 – Health

☐ ELECTING HEALTH INSURANCE

I certify that the information furnished in the enrollment process is complete and accurate to the best of my knowledge. In addition, I understand that if there are any changes in the information, it is my responsibility to report this to my employer at the time of the change. I accept responsibility for any claims paid incorrectly because of the incomplete or inaccurate information provided during the enrollment process.

I authorize hospitals, physicians or other providers of service to furnish SIHO (acting as the TPA for my employer), upon request, any and all reports and records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents under age 26 after this date, together with like reports and records or copies thereof of earlier services for purposes of processing this application and for purposes of determining the eligibility of any claim for payment or the propriety of any payment made. In recognition of the legitimate interest of my employer in reviewing historical data setting forth the volume, nature and costs of healthcare services paid by my employer, I hereby authorize SIHO to provide my employer plan with information relating to medical services and treatment rendered to me and/or my dependents under age 26 listed on this application.

I, for myself and for those of my eligible dependents listed above, hereby agree to abide by the rules, regulations and terms of my employer's group health plan documents as such documents may be amended. I shall cooperate and assist SIHO in the exercise of the subrogation and coordination of benefits rights of my employer's plan. I certify that the information furnished is true and complete to the best of my knowledge and I understand that inaccurate information provided regarding my coverage on other plans, my spouse's access to other coverage, or dependents' coverage under employer provided plans may affect my of claims and my access to insurance. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I will be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Signature Date

Print Name

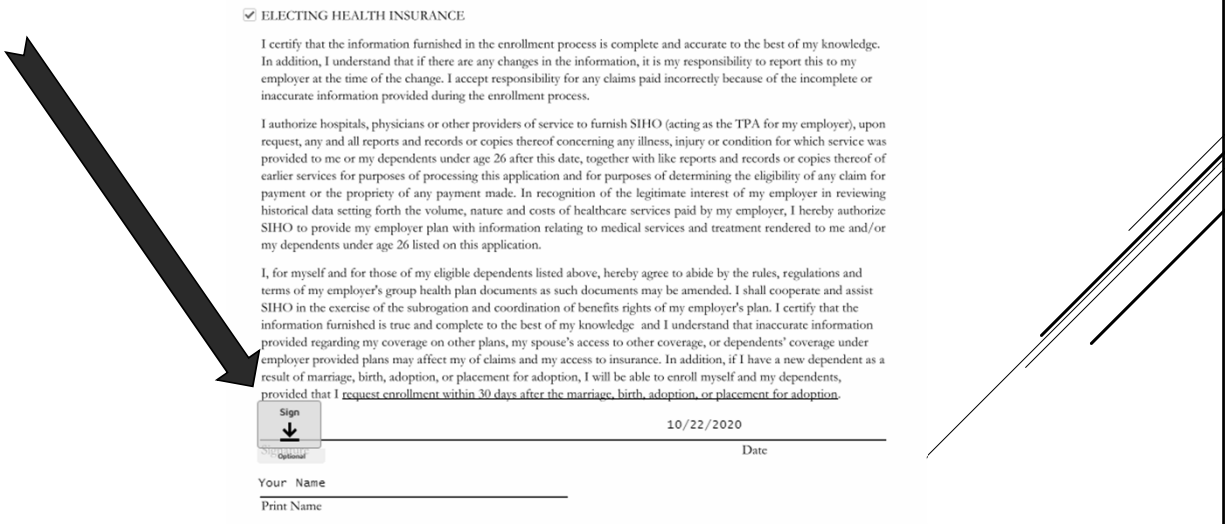
☐ DECLINING HEALTH INSURANCE AT THIS TIME?

I am declining enrollment for myself and dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Signature Date

Print Name

ONCE THE BOX IS CHECKED, YOUR NAME, THE DATE, AND A SIGNATURE BOX WILL APPEAR.



☑ ELECTING HEALTH INSURANCE

I certify that the information furnished in the enrollment process is complete and accurate to the best of my knowledge. In addition, I understand that if there are any changes in the information, it is my responsibility to report this to my employer at the time of the change. I accept responsibility for any claims paid incorrectly because of the incomplete or inaccurate information provided during the enrollment process.

I authorize hospitals, physicians or other providers of service to furnish SIHO (acting as the TPA for my employer), upon request, any and all reports and records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents under age 26 after this date, together with like reports and records or copies thereof of earlier services for purposes of processing this application and for purposes of determining the eligibility of any claim for payment or the propriety of any payment made. In recognition of the legitimate interest of my employer in reviewing historical data setting forth the volume, nature and costs of healthcare services paid by my employer, I hereby authorize SIHO to provide my employer plan with information relating to medical services and treatment rendered to me and/or my dependents under age 26 listed on this application.

I, for myself and for those of my eligible dependents listed above, hereby agree to abide by the rules, regulations and terms of my employer's group health plan documents as such documents may be amended. I shall cooperate and assist SIHO in the exercise of the subrogation and coordination of benefits rights of my employer's plan. I certify that the information furnished is true and complete to the best of my knowledge and I understand that inaccurate information provided regarding my coverage on other plans, my spouse's access to other coverage, or dependents' coverage under employer provided plans may affect my of claims and my access to insurance. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I will be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Sign

Optional

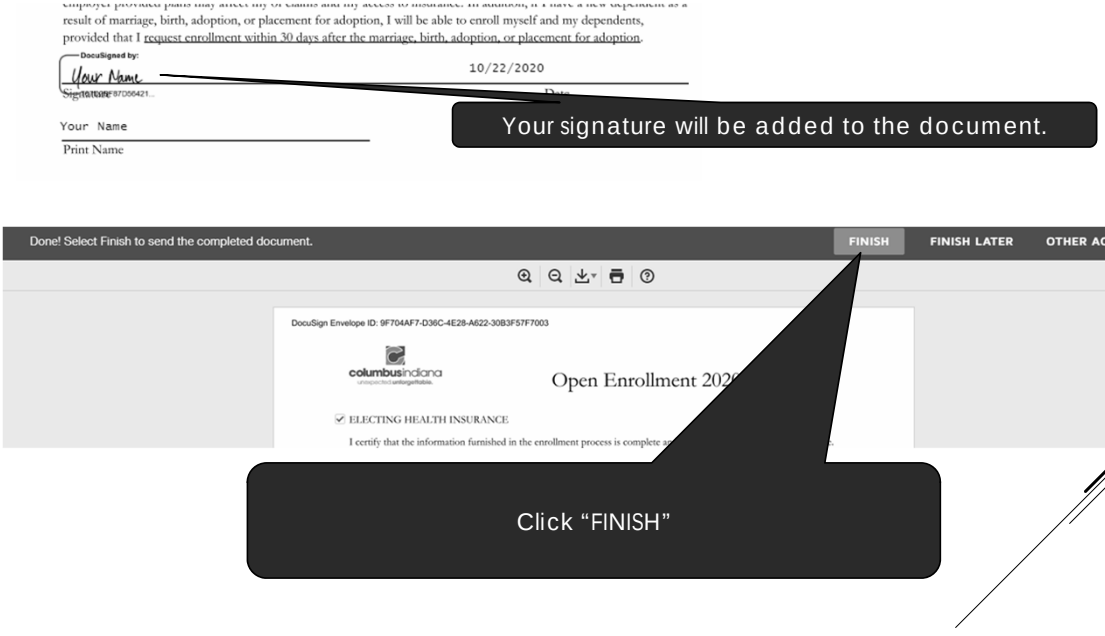
10/22/2020

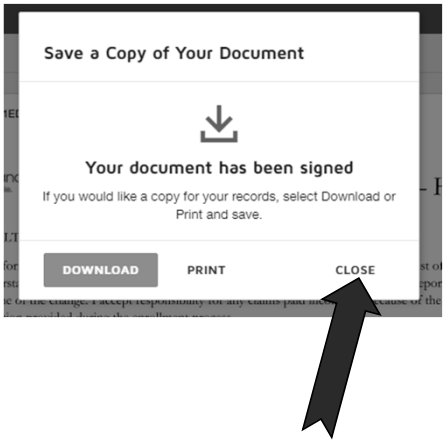
Date

Your Name

Print Name

CLICK THE "SIGN" BOX. USE THE AUTOMATIC SIGNATURE STYLE, THEN CLICK "ADOPT AND SIGN"



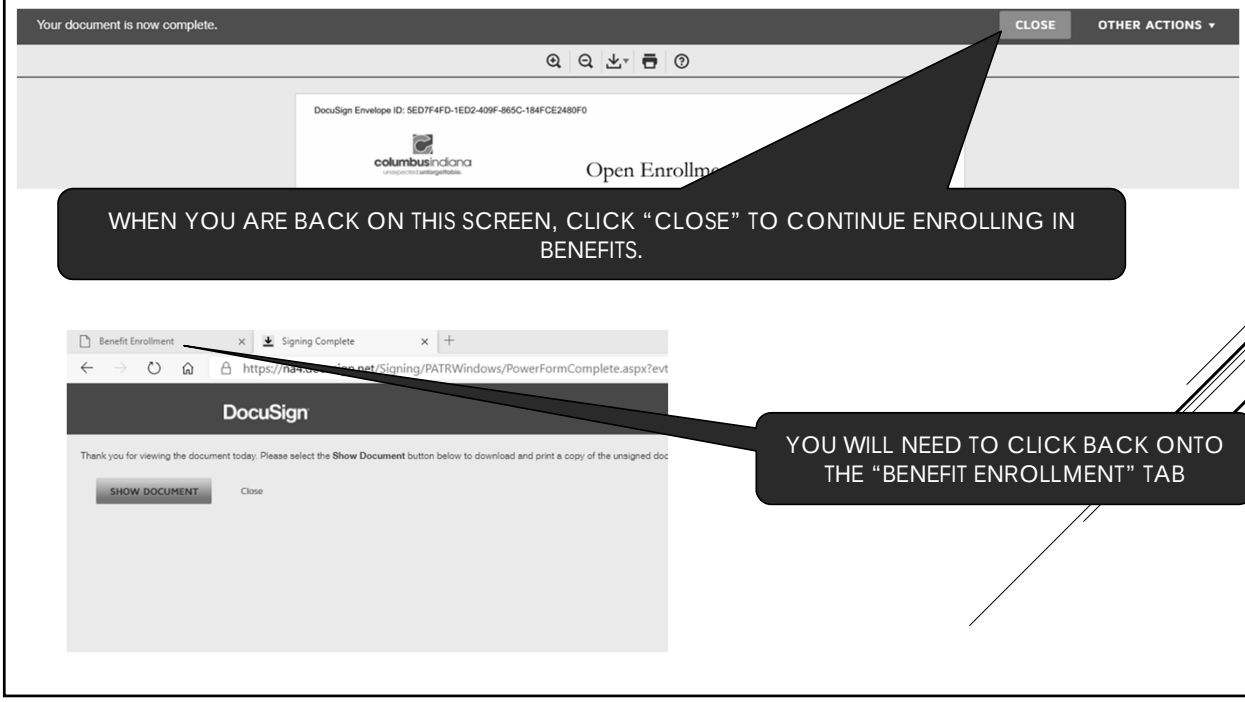


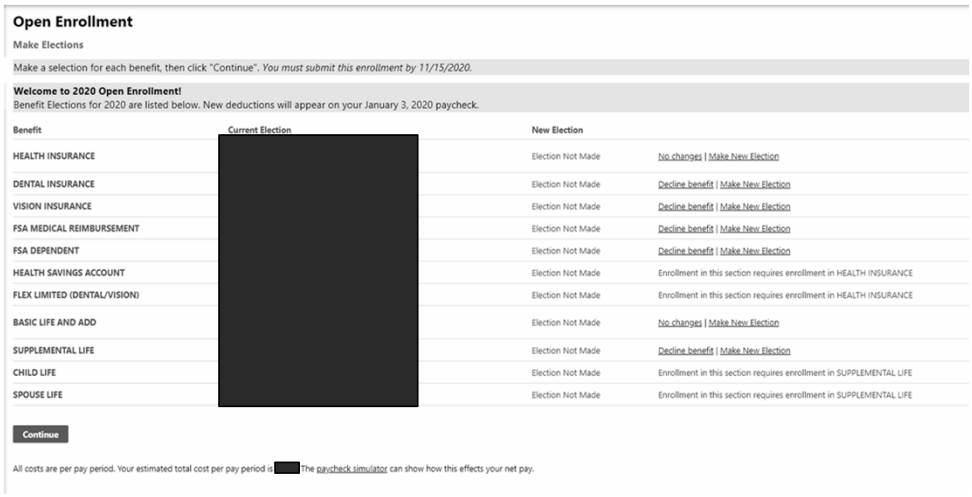
WHEN THIS APPEARS, YOU HAVE THE OPTION TO DOWNLOAD THE FILE TO YOUR COMPUTER OR PRINT IT.

YOU DON'T HAVE TO DO EITHER ONE. DOCUSIGN WILL HAVE SENT A COPY TO YOUR EMAIL.

PLEASE CLICK "CLOSE"

***IF YOU HAVE THE ABILITY TO DOWNLOAD AND SAVE THIS DOCUMENT, YOU WILL BE ABLE TO UPLOAD IT TO YOUR ENROLLMENT ON THE FINAL SCREEN. THIS WILL ATTACH THE DOCUMENT TO YOUR OPEN ENROLLMENT RECORDS.





Open Enrollment

Make Elections

Make a selection for each benefit, then click "Continue". *You must submit this enrollment by 11/15/2020.*

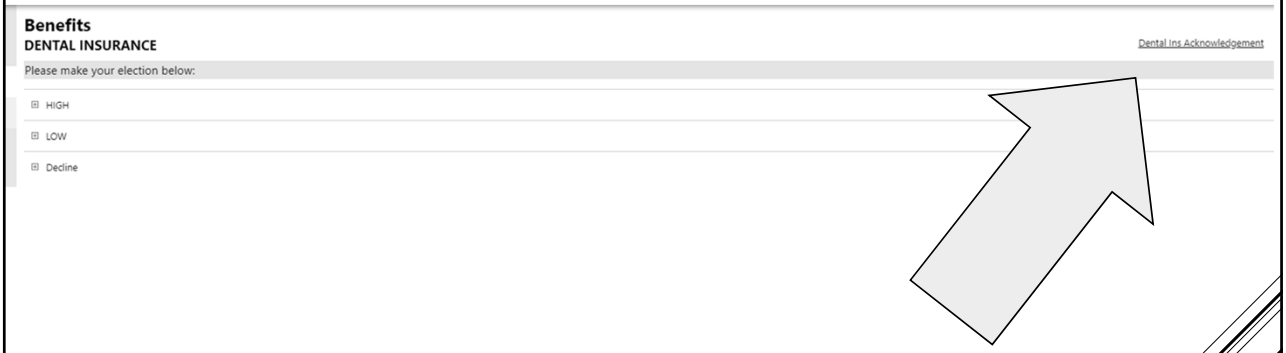
Welcome to 2020 Open Enrollment!
Benefit Elections for 2020 are listed below. New deductions will appear on your January 3, 2020 paycheck.

Benefit	Current Election	New Election	
HEALTH INSURANCE	[redacted]	Election Not Made	No changes | Make New Election
DENTAL INSURANCE		Election Not Made	Decline benefit | Make New Election
VISION INSURANCE		Election Not Made	Decline benefit | Make New Election
FSA MEDICAL REIMBURSEMENT		Election Not Made	Decline benefit | Make New Election
FSA DEPENDENT		Election Not Made	Decline benefit | Make New Election
HEALTH SAVINGS ACCOUNT		Election Not Made	Enrollment in this section requires enrollment in HEALTH INSURANCE
FLEX LIMITED (DENTAL/VISION)		Election Not Made	Enrollment in this section requires enrollment in HEALTH INSURANCE
BASIC LIFE AND ADD		Election Not Made	No changes | Make New Election
SUPPLEMENTAL LIFE		Election Not Made	Decline benefit | Make New Election
CHILD LIFE		Election Not Made	Enrollment in this section requires enrollment in SUPPLEMENTAL LIFE
SPOUSE LIFE		Election Not Made	Enrollment in this section requires enrollment in SUPPLEMENTAL LIFE

Continue

All costs are per pay period. Your estimated total cost per pay period is [redacted] The paycheck simulator can show how this effects your net pay.

DENTAL - YOU HAVE THE OPTION OF ELECTING: MAKE NEW ELECTION OR DECLINE BENEFIT. YOU MUST ACTIVELY MAKE A CHOICE FOR EACH BENEFIT.



Benefits
DENTAL INSURANCE

Dental Ins Acknowledgement

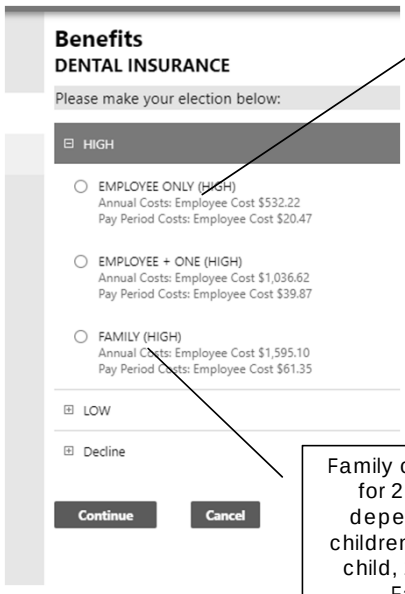
Please make your election below:

- ⊞ HIGH
- ⊞ LOW
- ⊞ Decline

IF YOU ARE DECLINING DENTAL COVERAGE, YOU WILL NEED TO CLICK ON THE BLUE "DENTAL INSURANCE ACKNOWLEDGEMENT" AND DECLINE THE COVERAGE ON THE DOCUMENT.

YOU WILL BE TAKEN TO A DIFFERENT WEBSITE SO THAT YOU CAN SIGN THE DOCUMENT IN DOCUSIGN.

PLEASE SAVE OR PRINT THE DOCUMENT AFTER YOU SIGN IT.



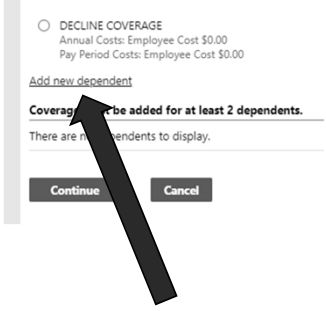
Employee plus One is dependent

Family coverage is for 2 or more dependents. 2 children? Family. 1 child, 1 spouse? Family

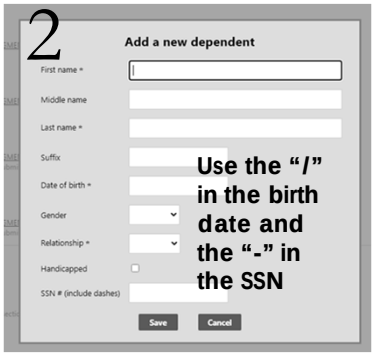
IF YOU ARE ELECTING DENTAL COVERAGE – EITHER TYPE – YOU WILL NEED TO CREATE THE DEPENDENT AND/OR MAKE SURE TO ADD THE DEPENDENT TO THE POLICY.

SEE THE NEXT SCREEN.

1



2

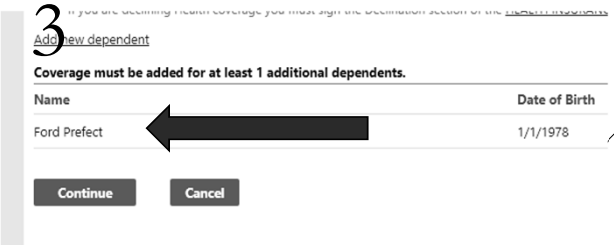


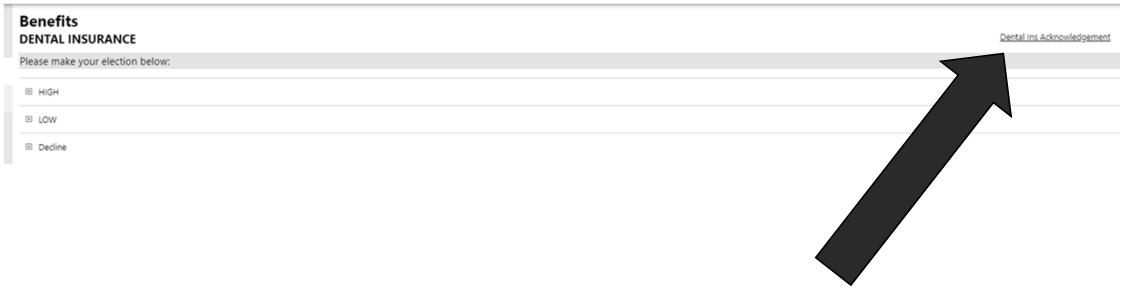
Use the "/" in the birth date and the "-" in the SSN

IF YOUR DEPENDENTS ARE NOT LISTED (IMAGE 1) , YOU WILL NEED TO ADD THEM. (IMAGE 2) IN ORDER FOR YOUR DEPENDENT TO BE COVERED THEY MUST BE LISTED AT THE BOTTOM AREA OF THE PAGE. (IMAGE 3)

IF YOU DEPENDENTS ARE LISTED, USE THE DROP DOWN ARROW TO SELECT AND ADD EACH ONE. THEY MUST BE LISTED INDIVIDUALLY AT THE BOTTOM OF THE PAGE.

3

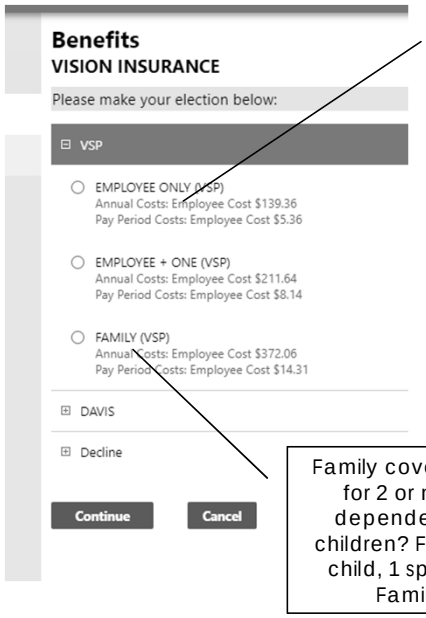




IF YOU ARE DECLINING VISION COVERAGE, YOU WILL NEED TO CLICK ON THE BLUE "VISION INSURANCE ACKNOWLEDGEMENT" AND DECLINE THE COVERAGE ON THE DOCUMENT.

YOU WILL BE TAKEN TO A DIFFERENT WEBSITE SO THAT YOU CAN SIGN THE DOCUMENT IN DOCUSIGN.

PLEASE SAVE OR PRINT THE DOCUMENT AFTER YOU SIGN IT.



Employee plus One is dependent

Family coverage is for 2 or more dependents. 2 children? Family. 1 child, 1 spouse? Family

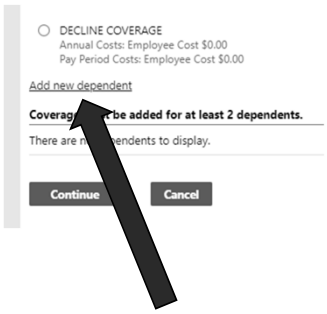
IF YOU ARE ELECTING VISION COVERAGE – EITHER TYPE – YOU WILL NEED TO

- **ADD DEPENDENTS IF NECESSARY**

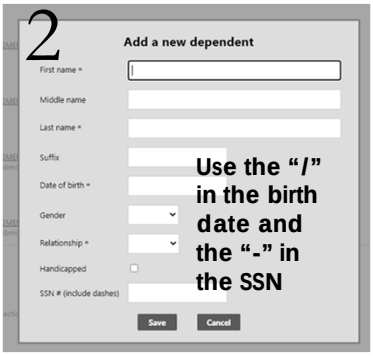
YOU WILL BE TAKEN TO A DIFFERENT WEBSITE SO THAT YOU CAN SIGN THE DOCUMENT IN DOCUSIGN.

PLEASE SAVE OR PRINT THE DOCUMENT AFTER YOU SIGN IT.

1



2



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IF YOUR DEPENDENTS ARE NOT LISTED (IMAGE 1) , YOU WILL NEED TO ADD THEM. (IMAGE 2) IN ORDER FOR YOUR DEPENDENT TO BE COVERED THEY MUST BE LISTED AT THE BOTTOM AREA OF THE PAGE. (IMAGE 3)

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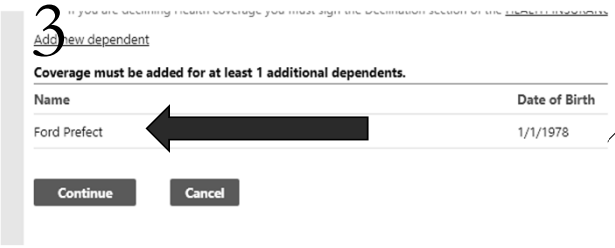
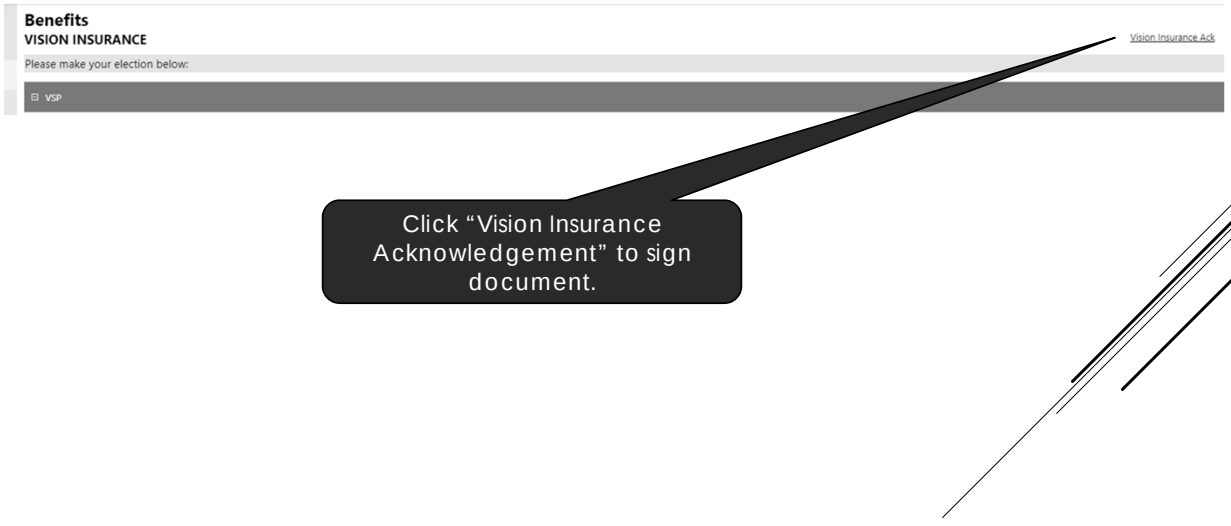
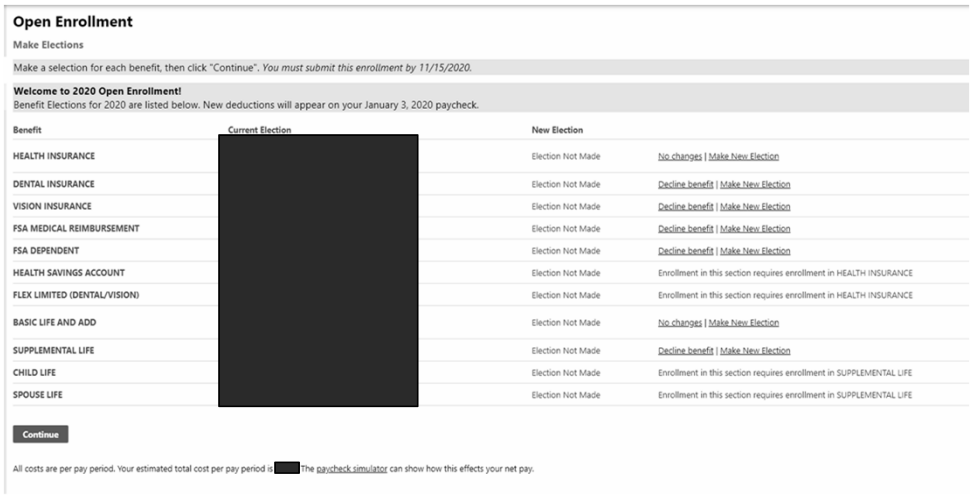
3





Click "Vision Insurance Acknowledgement" to sign document.



Open Enrollment

Make Elections

Make a selection for each benefit, then click "Continue". *You must submit this enrollment by 11/15/2020.*

Welcome to 2020 Open Enrollment!
Benefit Elections for 2020 are listed below. New deductions will appear on your January 3, 2020 paycheck.

Benefit	Current Election	New Election	
HEALTH INSURANCE	[redacted]	Election Not Made	No changes | Make New Election
DENTAL INSURANCE		Election Not Made	Decline benefit | Make New Election
VISION INSURANCE		Election Not Made	Decline benefit | Make New Election
FSA MEDICAL REIMBURSEMENT		Election Not Made	Decline benefit | Make New Election
FSA DEPENDENT		Election Not Made	Decline benefit | Make New Election
HEALTH SAVINGS ACCOUNT		Election Not Made	Enrollment in this section requires enrollment in HEALTH INSURANCE
FLEX LIMITED (DENTAL/VISION)		Election Not Made	Enrollment in this section requires enrollment in HEALTH INSURANCE
BASIC LIFE AND ADD		Election Not Made	No changes | Make New Election
SUPPLEMENTAL LIFE		Election Not Made	Decline benefit | Make New Election
CHILD LIFE		Election Not Made	Enrollment in this section requires enrollment in SUPPLEMENTAL LIFE
SPOUSE LIFE		Election Not Made	Enrollment in this section requires enrollment in SUPPLEMENTAL LIFE

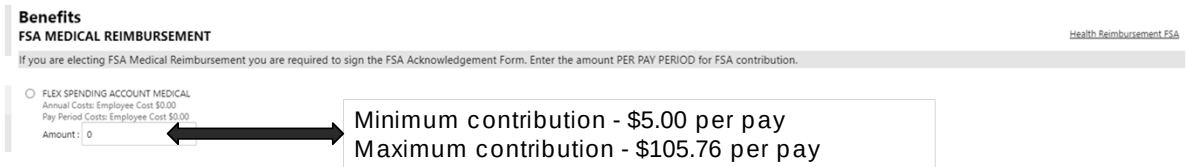
Continue

All costs are per pay period. Your estimated total cost per pay period is [redacted] The paycheck simulator can show how this effects your net pay.

YOU HAVE THE OPTION OF ELECTING: NO CHANGES, MAKE NEW ELECTION OR DECLINE BENEFIT. YOU MUST ACTIVELY MAKE A CHOICE FOR EACH BENEFIT.

	Type of coverage	Uses	Minimum Employee Contribution	Maximum Employee Contribution	Employer amount (annual)	For additional information
FSA (Flexible Spending Account) Healthcare reimbursement	PPO or No City Coverage	You can use funds in your FSA to pay for certain medical and dental expenses for you, your spouse if you're married, and your dependents.	$5 per pay ($130 annual)	$105.76 per pay ($2,749.76 annual)	N/A	Eligible healthcare FSA expenses
FSA (Flexible Spending Account) Dependent Care	PPO or No City Coverage	A Dependent Care FSA is a pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare.	$5 per pay ($130 annual)	$96.15 per pay ($2,499.90 annual)	N/A	Eligible dependent care FSA expenses
Limited Dental / Vision	HDHP	This pre-tax benefit account helps you save on eligible out-of-pocket dental and vision care expenses.	$5 per pay ($130 annual)	$105.76 per pay ($2,749.76 annual)	N/A	Limited Expense Health Care FSA Eligible Expenses

FOR PPO HEALTH CARE OR NO HEALTH ELECTIONS ONLY



IF YOU ARE ELECTING THE FLEXIBLE SPENDING ACCOUNT MEDICAL REIMBURSEMENT (FSA) ENTER THE AMOUNT YOU WANT DEDUCTED PER PAY.

YOU WILL ALSO NEED TO SIGN THE ACKNOWLEDGEMENT FOR EACH TYPE OF ACCOUNT YOU ELECT.

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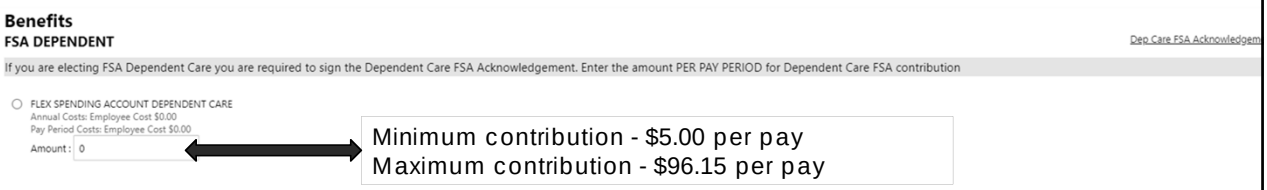
FOR PPO HEALTH CARE OR NO HEALTH ELECTIONS ONLY



IF YOU ARE ELECTING THE FLEXIBLE SPENDING ACCOUNT DEPENDENT CARE (FSA) ENTER THE AMOUNT YOU WANT DEDUCTED PER PAY.

YOU WILL ALSO NEED TO SIGN THE ACKNOWLEDGEMENT FOR EACH TYPE OF ACCOUNT YOU ELECT.

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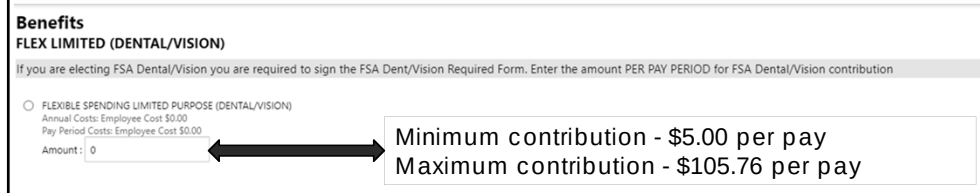
FOR PPO HEALTH CARE OR NO HEALTH ELECTIONS ONLY



IF YOU ARE ELECTING THE FLEXIBLE SPENDING ACCOUNT DEPENDENT CARE (FSA) ENTER THE AMOUNT YOU WANT DEDUCTED PER PAY.

YOU WILL ALSO NEED TO SIGN THE ACKNOWLEDGEMENT FOR EACH TYPE OF ACCOUNT YOU ELECT.

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THE HEALTH SAVINGS ACCOUNT IS FOR HDHP ONLY

IF YOU CURRENTLY HAVE AN HDHP ACCOUNT, YOU DO NOT NEED TO COMPLETE THE FIRST FINANCIAL APPLICATION.

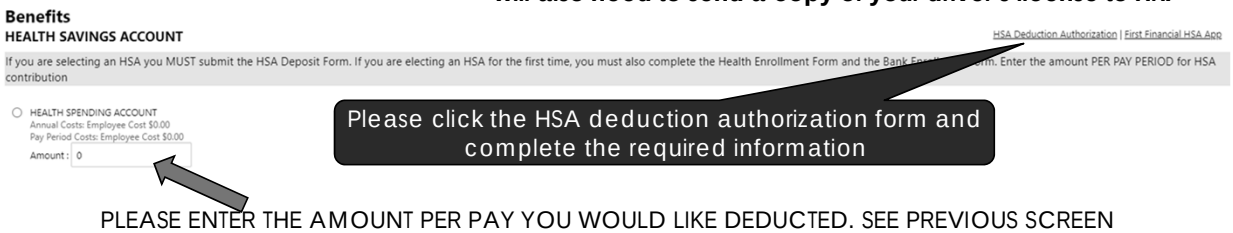
YOU CAN ONLY CONTRIBUTE TO THE HSA IF YOU ELECT HDHP.

CURRENT (2020) HSA HOLDERS WHO CONTINUE WITH AN HSA FOR 2021 WILL RECEIVE THE CITY'S DISBURSEMENT OF $500 FOR EMPLOYEE ONLY AND $1000 FOR EMPLOYEE + HEALTH PLANS.

ONE HALF OF THIS AMOUNT WILL BE DEPOSITED IN JANUARY AND JULY. YOU MUST BE AN ACTIVE EMPLOYEE ON THE DATE OF THE DEPOSIT.

	Type of coverage	Uses	Minimum Employee Contribution	Maximum Employee Contribution	Employer amount (annual)	For additional information
HSA (Health Savings Account)	HDHP	A HSA is a tax-advantaged account designed to allow people with certain types of health insurance plans to save for medical expenses.	$5 per pay ($130 annual)	*Employee only* - $119.23 per pay *Employee plus* - $238.46 per pay	*Employee only* - $250 in January / $250 in July ($500 annual) *Employee Plus* - $500 January / $500 July ($1,000 annual)	Eligible HSA expenses

New to an HSA? You need to complete both of these documents! You will also need to send a copy of your driver's license to HR.



Please click the HSA deduction authorization form and complete the required information

PLEASE ENTER THE AMOUNT PER PAY YOU WOULD LIKE DEDUCTED. SEE PREVIOUS SCREEN FOR MIN/MAX AMOUNTS

*IF YOU ARE A CURRENT HSA HOLDER, YOU WILL NEED TO COMPLETE THE AUTHORIZATION FOR DEDUCTION.

*IF YOU ARE NEW TO THE HSA, YOU WILL NEED TO COMPLETE THE AUTHORIZATION FOR DEDUCTION.

*IF YOU ARE A CURRENT HSA HOLDER, YOU DO NOT NEED TO COMPLETE THE ACCOUNT APPLICATION.

*IF YOU ARE NEW TO THE HSA, YOU MUST TO COMPLETE THE FIRST FINANCIAL HSA APP.

BASIC LIFE AND ADD

OneAmerica now provides the Life and Accidental Death/Dismemberment insurance for the City.

They require a signed beneficiary form.

EVEN IF YOUR BENEFITS OR YOUR BENEFICIARIES ARE NOT CHANGING, YOU WILL NEED TO CLICK ON THE "Beneficiary Designation Form" AND COMPLETE THIS INFORMATION.

SUPPLEMENTAL / VOLUNTARY LIFE

ONE AMERICA IS NOW THE LIFE INSURANCE PROVIDER FOR THE CITY AND YOU ARE NOW ABLE TO CHOOSE UP TO $100,000 OF LIFE INSURANCE WITHOUT MEDICAL QUESTIONS – ***EVEN IF YOU DO NOT CURRENTLY HAVE LIFE INSURANCE.*** *BUT ONLY DURING OPEN ENROLLMENT THIS YEAR!*

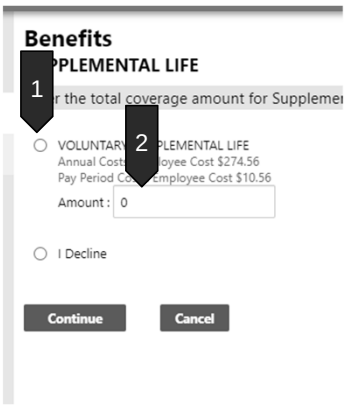
THIS IS NORMALLY ONLY AVAILABLE TO NEW EMPLOYEES.

EMPLOYEES CAN INCREASE THEIR CURRENT COVERAGE TO $100,000 AS WELL AS ENROLL FOR NEW COVERAGE UP TO $100,000 WITHOUT MEDICAL QUESTIONS.

IF YOU ELECT MORE THAN $100,000, MEDICAL QUESTIONS WILL APPLY.

YOU MUST ELECT AT LEAST $20,000 UP TO $100,000 IN $1,000 INCREMENTS

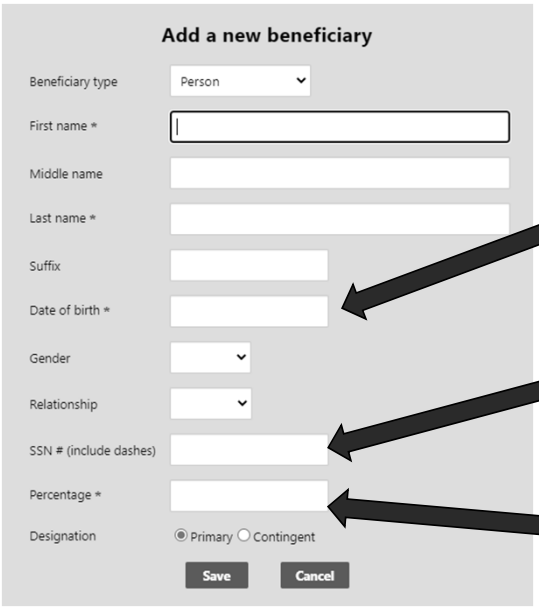
YOU CANNOT ELECT MORE THAN 5X YOUR SALARY OR MORE THAN $500,000.



YOU WILL NEED TO CLICK THE BUBBLE BEFORE "VOLUNTARY/SUPPLEMENTAL LIFE

PUT THE TOTAL LIFE INSURANCE YOU WANT IN THIS BOX – NOT THE COST PER PAY. DO NOT USE A COMMA

YOU WILL SEE YOUR COST PER PAY ON THE MAIN SCREEN.



When you add a new beneficiary –

*Make sure to use the "/" in the date of birth such as 11/21/1982

*Make sure to use the "-" in the SSN# such as 555-55-5555

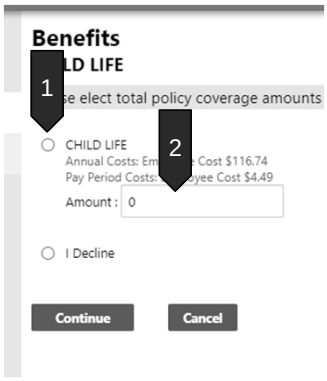
*Do not use the "%" sign in the percentage box

CHILD LIFE

IN ORDER TO ELECT CHILD LIFE INSURANCE YOU MUST CARRY INSURANCE ON YOURSELF

THIS IS NORMALLY ONLY AVAILABLE TO NEW EMPLOYEES.

Option 1: $2,500 (all children ages 6 months to 26 years for 23¢ per pay)
Option 2: $5,000 (all children ages 6 months to 26 years for 46¢ per pay)
Option 3: $7,500 (all children ages 6 months to 26 years for 69¢ per pay)
Option 2: $10,000 (all children ages 6 months to 26 years for 92¢ per pay)



YOU WILL NEED TO CLICK THE BUBBLE BEFORE "CHILD LIFE"

PUT THE TOTAL LIFE INSURANCE YOU WANT IN THIS BOX – NOT THE COST PER PAY. DO NOT USE A COMMA

YOU WILL SEE YOUR COST PER PAY ON THE MAIN SCREEN.

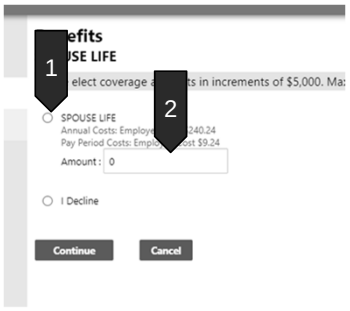
SPOUSE LIFE

IN ORDER TO ELECT SPOUSE LIFE INSURANCE YOU MUST CARRY INSURANCE ON YOURSELF

THIS IS NORMALLY ONLY AVAILABLE TO NEW EMPLOYEES.

SPOUSE LIFE INSURANCE BENEFIT AMOUNT: YOU CAN ELECT UP TO $20,000 IN $5,000 INCREMENTS – NOT TO EXCEED 100% OF THE EMPLOYEE'S AMOUNT

Spouse Options												
Life & AD&D	**0-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$5,000	$.15	$.15	$.15	$.17	$.23	$.38	$.66	$1.13	$2.24	$2.94	$4.92	$4.92	$4.92
$10,000	$.30	$.30	$.30	$.34	$.47	$.76	$1.32	$2.26	$4.47	$5.88	$9.84	$9.84	$9.84
$15,000	$.45	$.45	$.45	$.51	$.70	$1.15	$1.98	$3.38	$6.71	$8.82	$14.76	$14.76	$14.76
$20,000	$.60	$.60	$.60	$.68	$.94	$1.53	$2.64	$4.51	$8.94	$11.76	$19.68	$19.68	$19.68

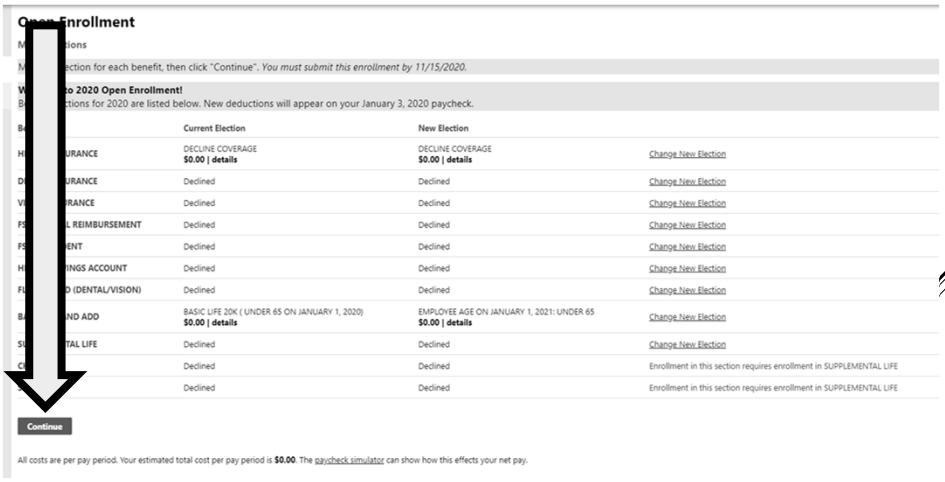


YOU WILL NEED TO CLICK THE BUBBLE BEFORE "SPOUSE LIFE"

PUT THE TOTAL LIFE INSURANCE YOU WANT IN THIS BOX – NOT THE COST PER PAY. DO NOT USE A COMMA

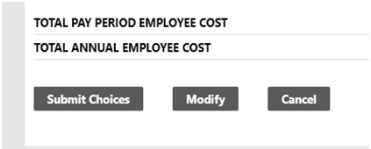
YOU WILL SEE YOUR COST PER PAY ON THE MAIN SCREEN.

WHEN YOU HAVE ELECTED OR DECLINE ALL BENEFITS AND ARE BACK TO THIS MAIN SCREEN, CLICK CONTINUE



REVIEW YOUR ENROLLMENT!

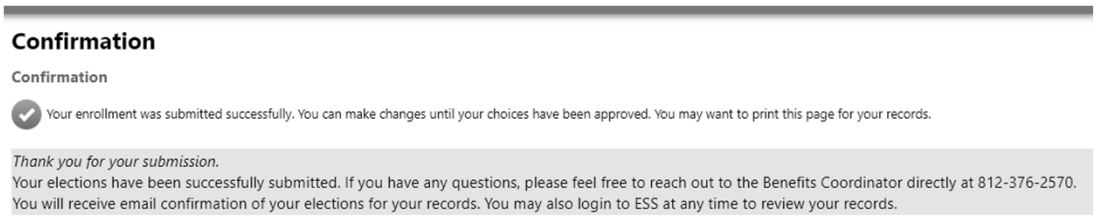
SCROLL DOWN THE PAGE AND MAKE SURE EVERYTHING IS CORRECT.



WHEN YOU GET TO THE BOTTOM –

*IF YOU NEED TO MAKE CHANGES, CLICK MODIFY

*IF EVERYTHING IS CORRECT, CLICK SUBMIT CHOICES

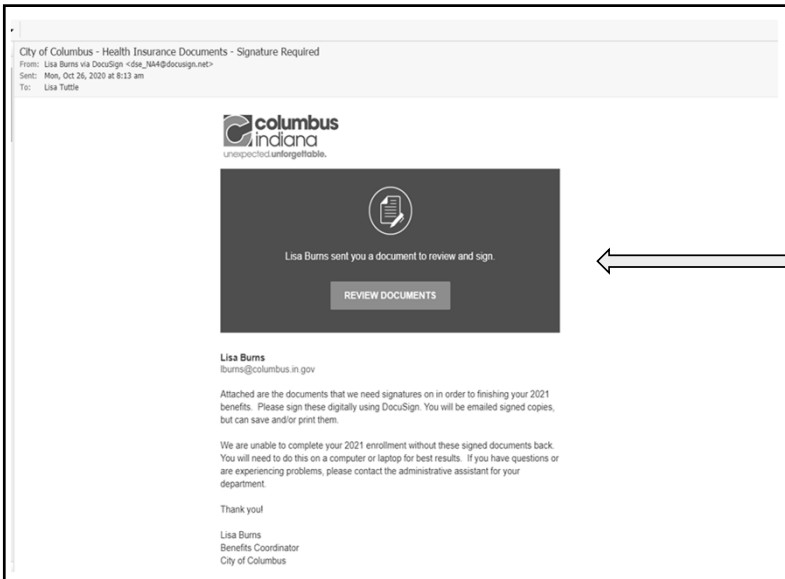


ON THE CONFIRMATION PAGE, IF YOU WANT TO PRINT YOUR ELECTIONS, PRESS CTRL AND "P".

YOU HAVE COMPLETED THE EMPLOYEE SELF SERVICE PORTION OF THIS.

IF YOU DID NOT COMPLETE THE DOCUSIGN DOCUMENTS AS YOU WENT THROUGH YOUR ENROLLMENT, PLEASE LOOK IN YOUR EMAIL INBOX IN THE NEXT COUPLE OF DAYS FOR AN IMPORTANT EMAIL.

WE WILL SEND YOU SOME PAPERS THAT YOU WILL NEED TO DIGITALLY SIGN BEFORE YOUR ENROLLMENT IS COMPLETE.



One final step if you did <u>not</u> sign the DocuSign forms.

Check your City Email. You should see a message that looks like this in the next couple of days.

Please check your spam folder if you don't see it soon.

Click "Review Documents" to be taken to Docusign's website to sign the required enrollment Paperwork.

If you continue to have trouble with this, please contact your department's administrative assistant.

Your enrollment is NOT complete until we receive these signed documents.

CONTACT THE HUMAN RESOURCES DEPARTMENT AT 376-2570 OR EMAIL LBURNS@COLUMBUS.IN.GOV FOR ASSISTANCE AND QUESTIONS.

Lisa Burns
Benefits Coordinator

Human Resources
City of Columbus

123 Washington Street
Columbus, Indiana 47201
Phone: (812) 376-2570
Fax: (812) 376-2579
lburns@columbus.in.gov