



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
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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

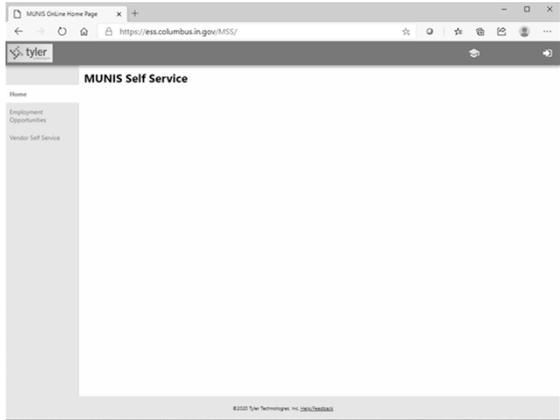
Friday, November 6

Need enrollment assistance?	In person help	Contact your department's administrative assistant or call 376-2570 for appointment	
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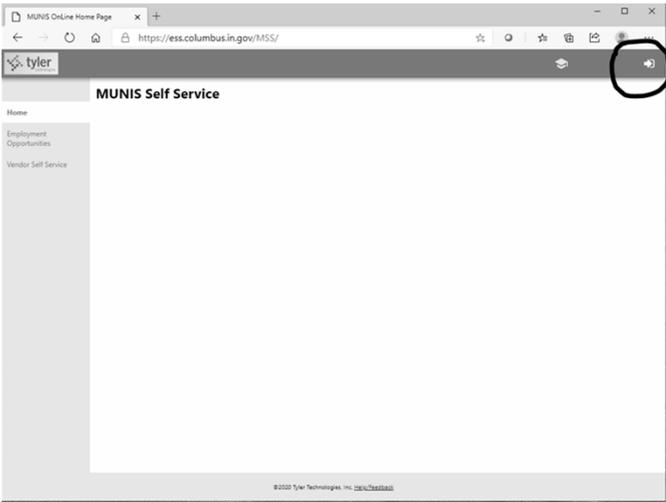
Saturday, November 7

Need enrollment assistance?	Phone help	12-3 pm	812-376-2570
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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		

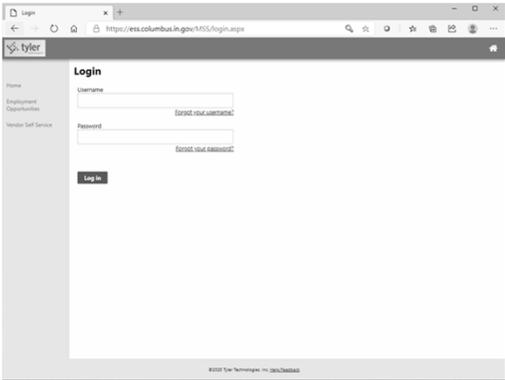


OPEN BROWSER AND GO TO
[HTTPS://ESS.COLUMBUS.IN.GOV/MSS/](https://ess.columbus.in.gov/MSS/)



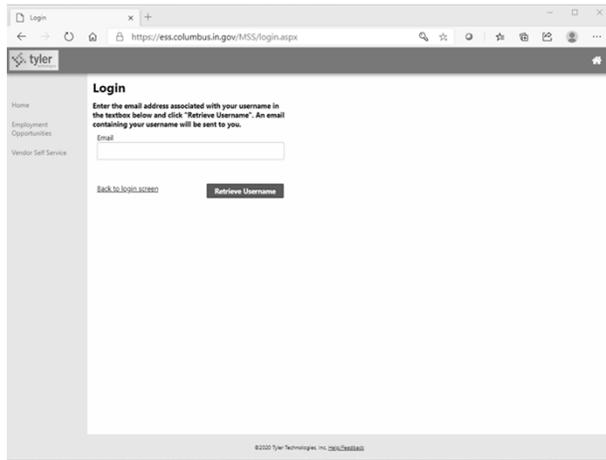
A screenshot of a web browser showing the "MUNIS Self Service" homepage. The browser's address bar displays "https://ess.columbus.in.gov/MSS/". The page features a navigation menu on the left with links for "Home", "Employment Opportunities", and "Vendor Self Service". A small icon resembling a doorway is circled in the top right corner of the page. The footer contains the text "© 2020 Tyler Technologies, Inc. 126127482403".

CLICK ON THE DOORWAY TO LOG IN



A screenshot of the login page. The browser's address bar shows "https://ess.columbus.in.gov/MSS/login.aspx". The page has a "Login" heading and two input fields: "Username" and "Password". Below the "Password" field is a link that says "Forgot your username?". Below the "Username" field is a link that says "Forgot your password?". A "Log In" button is located at the bottom of the form. The footer contains the text "© 2020 Tyler Technologies, Inc. 126127482403".

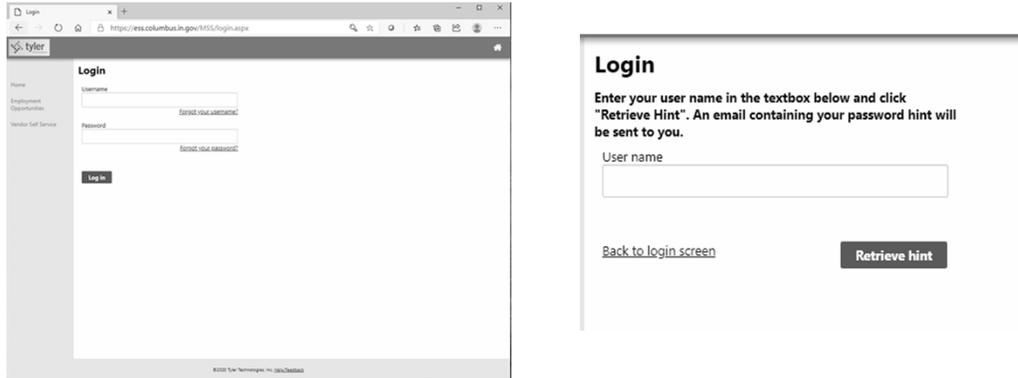
YOUR USERNAME IS YOUR EMPLOYEE ID NUMBER. IF YOU DO NOT KNOW YOUR EMPLOYEE ID NUMBER CLICK "FORGOT YOUR USERNAME?" OR CONTACT YOUR DEPARTMENT'S ADMINISTRATIVE ASSISTANT.



ENTER YOUR CITY EMAIL ADDRESS
HERE AND CLICK RETRIEVE USERNAME

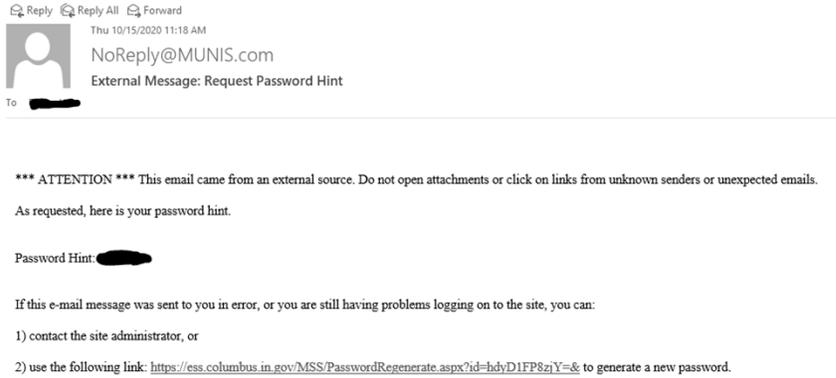
NoReply@MUNIS.com
External Message: Request Forgotten Username

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



The image shows two screenshots of a web application. The left screenshot is a browser window displaying a login page with fields for 'User name' and 'Password', and a 'Log in' button. The right screenshot is a close-up of the 'Retrieve hint' button, which is labeled 'Retrieve hint' and is located next to a 'Back to login screen' link.

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



The image shows an email message from NoReply@MUNIS.com. The subject is 'External Message: Request Password Hint'. The email body contains the following text:

*** ATTENTION *** This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

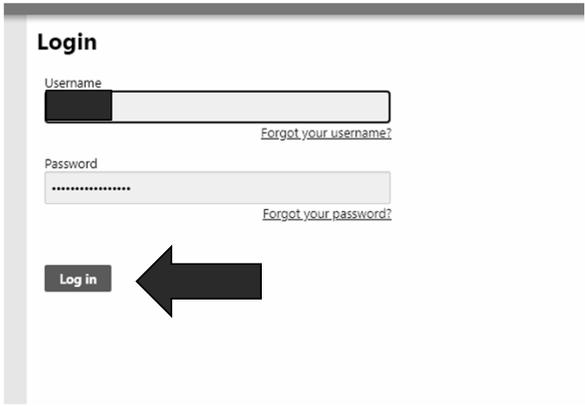
As requested, here is your password hint.

Password Hint: [REDACTED]

If this e-mail message was sent to you in error, or you are still having problems logging on to the site, you can:

- 1) contact the site administrator, or
- 2) use the following link: <https://ess.columbus.in.gov/MSS/PasswordRegenerate.aspx?id=hvD1FP8ziY=&> to generate a new password.

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!



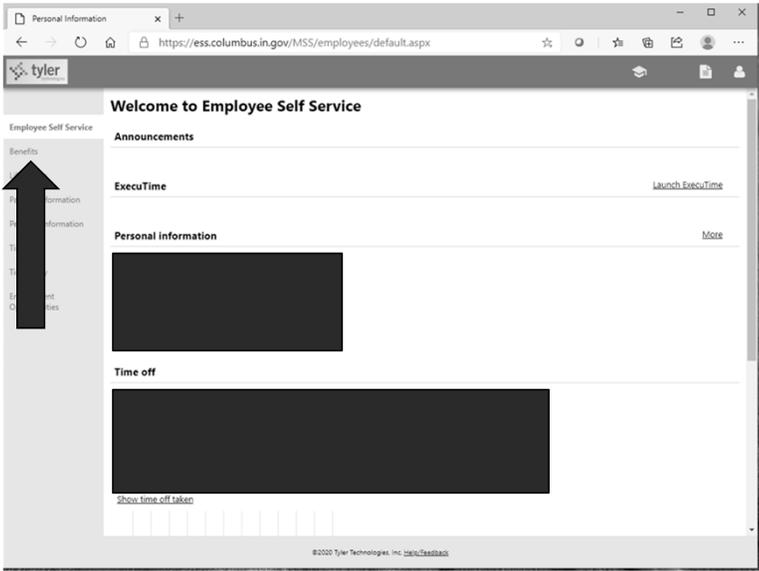
Login

Username [Forgot your username?](#)

Password [Forgot your password?](#)

Log in

AFTER YOU HAVE ENTERED YOUR USERNAME AND PASSWORD CLICK "LOG IN"



Personal Information x +
https://ess.columbus.in.gov/MSS/employees/default.aspx

tyler

Welcome to Employee Self Service

Employee Self Service

Announcements

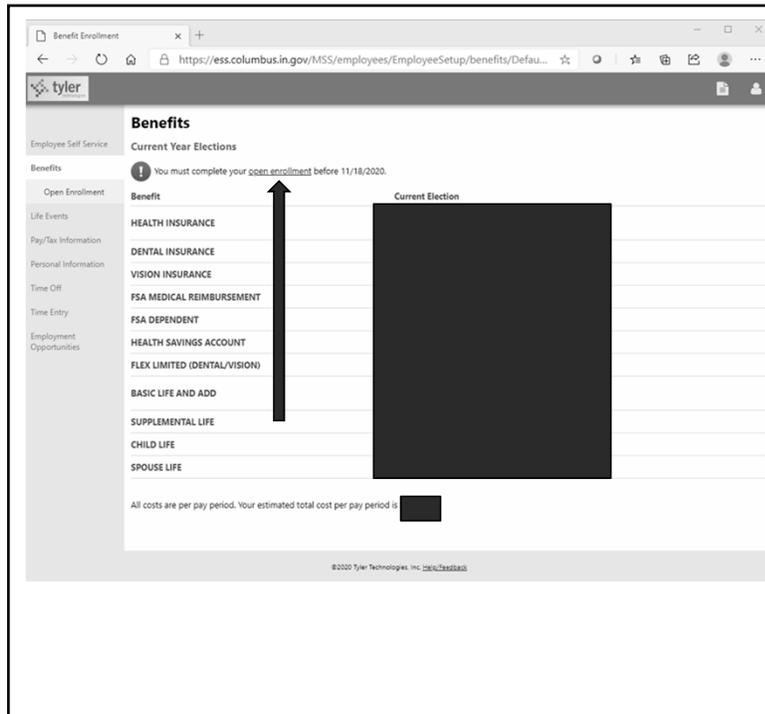
ExecuTime [Launch ExecuTime](#)

Personal information [More](#)

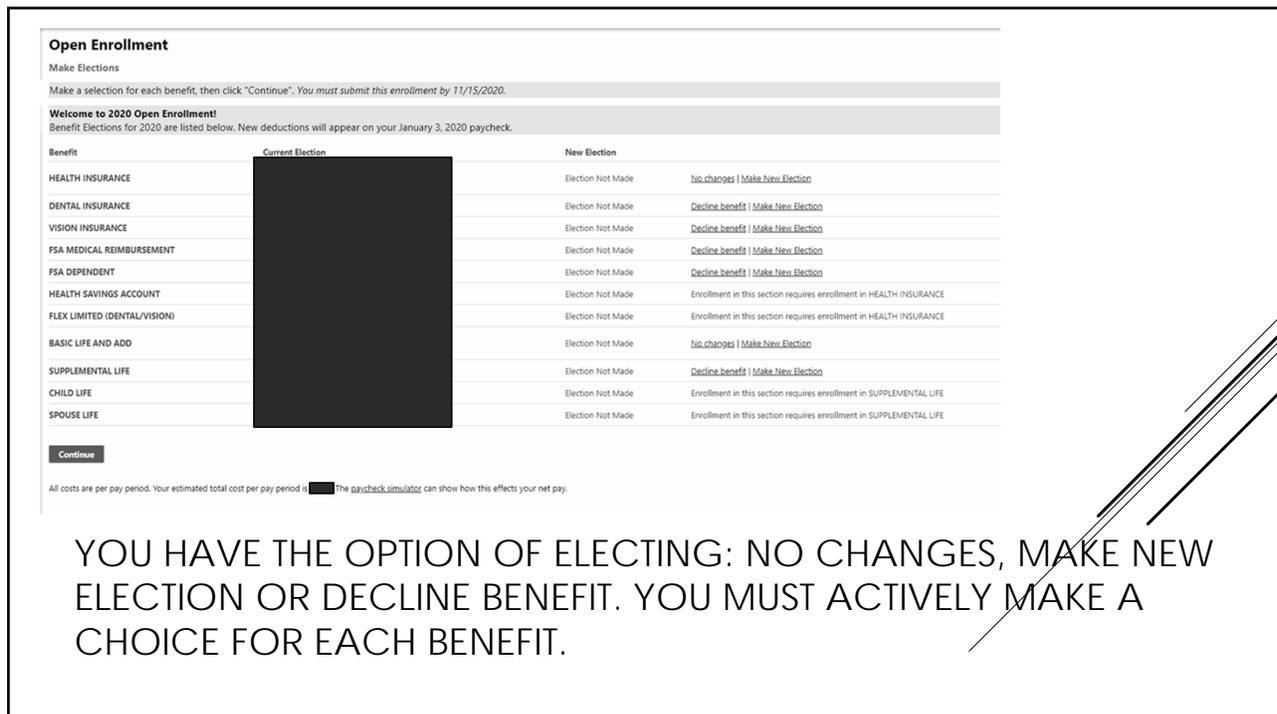
Time off [Show time off table](#)

©2009 Tyler Technologies, Inc. tssn_Test2a03

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.

1 New Election

DECLINE COVERAGE \$0.00 details	Change New Election
Election Not Made	Decline benefit Make New Election
Election Not Made	Decline benefit Make New Election
Election Not Made	Decline benefit Make New Election
Election Not Made	Decline benefit Make New Election

Click "make new election"

2 Benefits
HEALTH INSURANCE

For those electing the HDHP for the first time, you must select a plan.

- HIGH DEDUCTIBLE HEALTH PLAN
- PPO
- DECLINE COVERAGE
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00

Click the plus "+" sign to expand options

3

PPO

- PPO EMPLOYEE ONLY
Annual Costs: Employee Cost \$1,464.84
Pay Period Costs: Employee Cost \$56.34
- PPO EMPLOYEE + CHILD(REN)
Annual Costs: Employee Cost \$2,470.26
Pay Period Costs: Employee Cost \$95.01
- PPO EMPLOYEE + SPOUSE
Annual Costs: Employee Cost \$2,914.34
Pay Period Costs: Employee Cost \$112.09
- PPO FAMILY
Annual Costs: Employee Cost \$3,358.42
Pay Period Costs: Employee Cost \$128.99

Click the bubble in front of your choice

1 Benefits
HEALTH INSURANCE

For those electing the HDHP for the first time, you must select a plan.

- HIGH DEDUCTIBLE HEALTH PLAN
- HDHP EMPLOYEE ONLY
Annual Costs: Employee Cost \$1,016.60
Pay Period Costs: Employee Cost \$39.10
- HDHP EMPLOYEE + CHILD(REN)
Annual Costs: Employee Cost \$1,621.62
Pay Period Costs: Employee Cost \$62.37
- HDHP EMPLOYEE + SPOUSE
Annual Costs: Employee Cost \$1,979.38
Pay Period Costs: Employee Cost \$76.13
- HDHP FAMILY
Annual Costs: Employee Cost \$2,335.06
Pay Period Costs: Employee Cost \$89.81
- PPO
- DECLINE COVERAGE
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00

[Add new dependent](#)

Coverage must be added for at least 2 dependents.

There are no dependents to display.

2 Add a new dependent

First name *

Middle name

Last name *

Suffix

Date of birth *

Gender *

Relationship *

Handicapped

SSN # (include dashes)

Save Cancel

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

3 Add new dependent

Coverage must be added for at least 1 additional dependents.

Name	Date of Birth
Ford Prefect	1/1/1978

Continue Cancel

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.

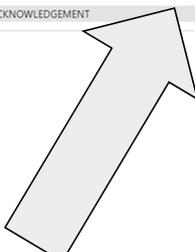
Benefits
HEALTH INSURANCE

[HEALTH INS ACKNOWLEDGEMENT | Spousal Employment Ver](#)

For those electing the HDHP for the first time, you must complete the First Financial application. All Employees must sign the appropriate section of the HEALTH INSURANCE ACKNOWLEDGEMENT

HIGH DEDUCTIBLE HEALTH PLAN

- HDHP EMPLOYEE ONLY
Annual Costs: Employee Cost \$1,016.60
Pay Period Costs: Employee Cost \$39.10
- HDHP EMPLOYEE + CHILD(REN)
Annual Costs: Employee Cost \$1,621.62
Pay Period Costs: Employee Cost \$62.37
- HDHP EMPLOYEE + SPOUSE



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.

PowerForm Signer Information

Fill in the name and email for each signing role listed below. Signers will receive an email inviting them to sign this document. Please enter your name and email to begin the signing process.

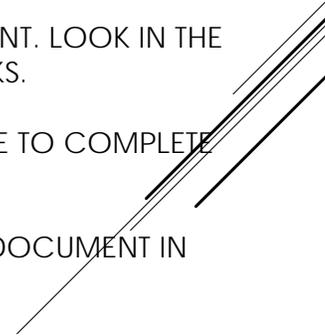
EMPLOYEE

Your Name: *

Your Email: *

BEGIN SIGNING

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.



PowerForm Signer Information

Fill in the name and email for each signing role listed below.
Signers will receive an email inviting them to sign this document.
Please enter your name and email to begin the signing process.

EMPLOYEE

Your Name: *
Full Name

Your Email: *
Email Address

BEGIN SIGNING

#1, Please type your first and last name here.

[HTTPS://POWERFORMS.DOCUSIGN.NET/](https://powerforms.docuSign.net/)
IS WHERE YOU WILL BE REDIRECTED TO
IN ORDER TO "SIGN" THE DOCUMENTS.

#2, Please type your email address here.

#3, click here

Please Review & Act on These Documents


Powered by DocuSign

Please read the Electronic Record and Signature Disclosure.
 I agree to use electronic records and signatures.

CONTINUE FINISH LATER OTHER ACTIONS

#1, check this box if it appears on your screen – otherwise click "CONTINUE"

Please read the Electronic Record and Signature Disclosure.
 I agree to use electronic records and signatures.

CONTINUE FINISH LATER OTHER ACTIONS

#2, click "CONTINUE"

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

columbusindiana
UNEMPLOYMENT COMPENSATION

Open Enrollment 2020 – Health

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

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

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.

 10/22/2020

Date

Your Name

Print Name

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

Adopt Your Signature

Confirm your name, initials, and signature.

* Required

Full Name* Initials*

SELECT STYLE DRAW UPLOAD

PREVIEW Change Style

DocuSigned by: DS

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen-and-paper signature or initial.

ADOPT AND SIGN CANCEL

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 10/22/2020 Date

Your Name

complete previous plan my 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.

DocuSigned by: 10/22/2020 Date

Signature ID: 87D06421...

Your Name

Print Name

Your signature will be added to the document.

Done! Select Finish to send the completed document.

FINISH FINISH LATER OTHER ACTIONS ▾

DocuSign Envelope ID: 9F704AF7-D36C-4E2B-A622-30B3F57F7003

Open Enrollment 2020

ELECTING HEALTH INSURANCE

I certify that the information furnished in the enrollment process is complete and accurate.

Click "FINISH"

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		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 affects 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 DOCUMENT.

PLEASE SAVE OR PRINT THE DOCUMENT AFTER YOU SIGN IT.

Benefits
DENTAL INSURANCE

Please make your election below:

HIGH

EMPLOYEE ONLY (HIGH)
Annual Costs: Employee Cost \$532.22
Pay Period Costs: Employee Cost \$20.47

EMPLOYEE + ONE (HIGH)
Annual Costs: Employee Cost \$1,036.62
Pay Period Costs: Employee Cost \$39.87

FAMILY (HIGH)
Annual Costs: Employee Cost \$1,595.10
Pay Period Costs: Employee Cost \$61.35

LOW

Decline

Continue **Cancel**

Employee plus One is dependent

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.

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

1

DECLINE COVERAGE
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00

[Add new dependent](#)

Coverage must be added for at least 2 dependents.

There are no dependents to display.

Continue **Cancel**

2

Add a new dependent

First name *

Middle name

Last name *

Suffix

Date of birth *

Gender

Relationship *

Handicapped

SSN # (include dashes)

Save **Cancel**

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

[Add new dependent](#)

Coverage must be added for at least 1 additional dependents.

Name	Date of Birth
Ford Prefect	1/1/1978

Continue **Cancel**

Benefits
DENTAL INSURANCE

Please make your election below:

- HIGH
- LOW
- Decline

[Dental Ins Acknowledgement](#)



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.

Benefits
VISION INSURANCE

Please make your election below:

- VSP
- EMPLOYEE ONLY (VSP)
Annual Costs: Employee Cost \$139.36
Pay Period Costs: Employee Cost \$5.36
- EMPLOYEE + ONE (VSP)
Annual Costs: Employee Cost \$211.64
Pay Period Costs: Employee Cost \$8.14
- FAMILY (VSP)
Annual Costs: Employee Cost \$372.06
Pay Period Costs: Employee Cost \$14.31

DAVIS

Decline

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

DECLINE COVERAGE
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00

[Add new dependent](#)

Coverage must be added for at least 2 dependents.

There are no dependents to display.

Continue **Cancel**

2

Add a new dependent

First name *

Middle name

Last name *

Suffix

Date of birth *

Gender

Relationship *

Handicapped

SSN # (include dashes)

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

Save **Cancel**

3

[Add new dependent](#)

Coverage must be added for at least 1 additional dependents.

Name	Date of Birth
Ford Prefect	1/1/1978

Continue **Cancel**

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.

Benefits

VISION INSURANCE

Please make your election below:

VSP

[Vision Insurance Ack](#)

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.

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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 affects 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

Benefits
FSA MEDICAL REIMBURSEMENT

[Health Reimbursement FSA](#)

If you are electing FSA Medical Reimbursement you are required to sign the FSA Acknowledgement Form. Enter the amount PER PAY PERIOD for FSA contribution.

FLEX SPENDING ACCOUNT MEDICAL
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00
Amount: 0

Minimum contribution - \$5.00 per pay
Maximum contribution - \$105.76 per pay

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.

FOR PPO HEALTH CARE OR NO HEALTH ELECTIONS ONLY

Benefits
FSA DEPENDENT

[Dep Care FSA Acknowledgem](#)

If you are electing FSA Dependent Care you are required to sign the Dependent Care FSA Acknowledgement. Enter the amount PER PAY PERIOD for Dependent Care FSA contribution

FLEX SPENDING ACCOUNT DEPENDENT CARE
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00
Amount: 0

Minimum contribution - \$5.00 per pay
Maximum contribution - \$96.15 per pay

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.

FOR PPO HEALTH CARE OR NO HEALTH ELECTIONS ONLY

Benefits

FLEX LIMITED (DENTAL/VISION)

[Dent/Vis FSA Acknowledgement](#)

If you are electing FSA Dental/Vision you are required to sign the FSA Dent/Vision Required Form. Enter the amount PER PAY PERIOD for FSA Dental/Vision contribution

FLEXIBLE SPENDING LIMITED PURPOSE (DENTAL/VISION)

Annual Costs: Employee Cost \$0.00

Pay Period Costs: Employee Cost \$0.00

Amount: 0

Minimum contribution - \$5.00 per pay
Maximum contribution - \$105.76 per pay

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.

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)	<i>Employee only</i> - \$119.23 per pay <i>Employee plus</i> - \$238.46 per pay	<i>Employee only</i> - \$250 in January / \$250 in July (\$500 annual) <i>Employee Plus</i> - \$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.

Benefits
HEALTH SAVINGS ACCOUNT [HSA Deduction Authorization](#) | [First Financial HSA App](#)

If you are selecting an HSA you MUST submit the HSA Deposit Form. If you are electing an HSA for the first time, you must also complete the Health Enrollment Form and the Bank Enrollment Form. Enter the amount PER PAY PERIOD for HSA contribution

HEALTH SPENDING ACCOUNT
Annual Costs: Employee Cost \$0.00
 Pay Period Costs: Employee Cost \$0.00
 Amount:

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.

Benefits

BASIC LIFE AND ADD

Please select Basic Life and Accidental Death and Dismemberment appropriate for your age bracket and provide beneficiary information. This benefit is provided to you by the City of Columbus at no cost to you.

- EMPLOYEE AGE ON JANUARY 1, 2021: UNDER 65
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00
- EMPLOYEE AGE ON JANUARY 1, 2021: BETWEEN 65 AND 70
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00
- EMPLOYEE AGE ON JANUARY 1, 2021: OVER 70
Annual Costs: Employee Cost \$0.00
Pay Period Costs: Employee Cost \$0.00

[Beneficiary Designation Form](#)

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.

Benefits

VOLUNTARY SUPPLEMENTAL LIFE

1 Enter the total coverage amount for Supplemental Life Insurance.

2 VOLUNTARY SUPPLEMENTAL LIFE
Annual Cost \$274.56 Employee Cost \$274.56
Pay Period Cost \$10.56 Employee Cost \$10.56
Amount:

I Decline

Continue **Cancel**

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.

Add a new beneficiary

Beneficiary type:

First name *

Middle name

Last name *

Suffix

Date of birth * →

Gender

Relationship

SSN # (include dashes) →

Percentage * →

Designation: Primary Contingent

Save **Cancel**

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)

Benefits

CHILD LIFE

1 Please select total policy coverage amounts

CHILD LIFE

Annual Costs: Employee Cost \$116.74

Pay Period Costs: Employee Cost \$4.49

Amount: 0

I Decline

Continue Cancel

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

Benefits
SPOUSE LIFE

1

2

Select coverage amounts in increments of \$5,000. Maximum amount is \$20,000.

SPOUSE LIFE
Annual Costs: Employee \$240.24
Pay Period Costs: Employee \$9.24

Amount:

I Decline

Continue Cancel

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

Open Enrollment

For each benefit, then click "Continue". You must submit this enrollment by 11/15/2020.

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

	Current Election	New Election	
HEALTH INSURANCE	DECLINE COVERAGE \$0.00 details	DECLINE COVERAGE \$0.00 details	Change New Election
DENTAL INSURANCE	Declined	Declined	Change New Election
VISION INSURANCE	Declined	Declined	Change New Election
PSYCH REIMBURSEMENT	Declined	Declined	Change New Election
PSYCH THERAPY	Declined	Declined	Change New Election
HEALTH SAVINGS ACCOUNT	Declined	Declined	Change New Election
FLU SHOT (DENTAL/VISION)	Declined	Declined	Change New Election
BASIC LIFE	BASIC LIFE 20K (UNDER 65 ON JANUARY 1, 2020) \$0.00 details	EMPLOYEE AGE ON JANUARY 1, 2021: UNDER 65 \$0.00 details	Change New Election
SUPPLEMENTAL LIFE	Declined	Declined	Change New Election
CREDIT LIFE	Declined	Declined	Enrollment in this section requires enrollment in SUPPLEMENTAL LIFE
DISABILITY	Declined	Declined	Enrollment in this section requires enrollment in SUPPLEMENTAL LIFE

[Continue](#)

All costs are per pay period. Your estimated total cost per pay period is \$0.00. The [payback simulator](#) can show how this affects your net pay.

Review your enrollment

Review

HEALTH INSURANCE

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

TOTAL PAY PERIOD EMPLOYEE COST

TOTAL ANNUAL EMPLOYEE COST

[Submit Choices](#)

[Modify](#)

[Cancel](#)

Confirmation

Confirmation

 Your enrollment was submitted successfully. You can make changes until your choices have been approved. You may want to print this page for your records.

Thank you for your submission.

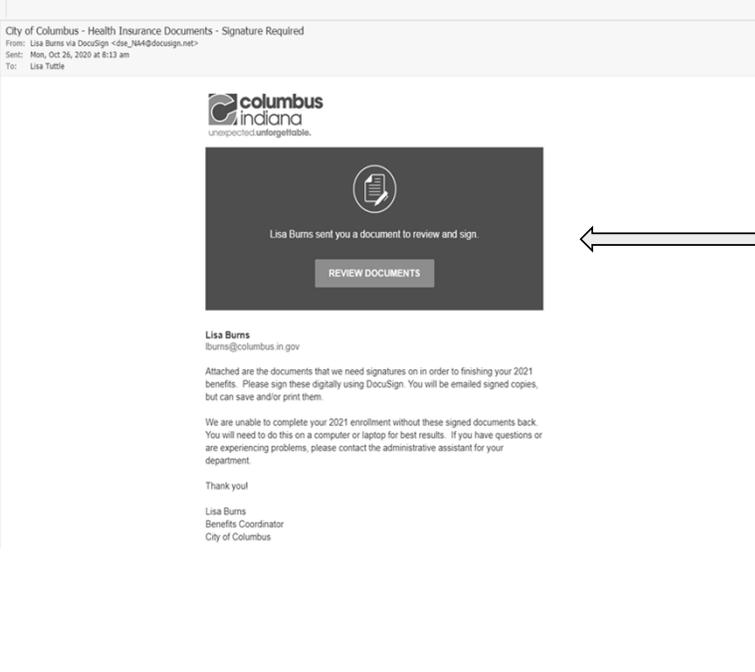
Your elections have been successfully submitted. If you have any questions, please feel free to reach out to the Benefits Coordinator directly at 812-376-2570. You will receive email confirmation of your elections for your records. You may also login to ESS at any time to review your records.

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.



City of Columbus - Health Insurance Documents - Signature Required
 From: Lisa Burns via DocuSign <Lisa_Burns@docuSign.net>
 Sent: Mon, Oct 26, 2020 at 8:13 am
 To: Lisa Tuttle


 unexpected.unforgettable.


 Lisa Burns sent you a document to review and sign.
 REVIEW DOCUMENTS

Lisa Burns
 lburns@columbus.in.gov

Attached are the documents that we need signatures on in order to finishing your 2021 benefits. Please sign these digitally using DocuSign. You will be emailed signed copies, but can save and/or print them.

We are unable to complete your 2021 enrollment without these signed documents back. You will need to do this on a computer or laptop for best results. If you have questions or are experiencing problems, please contact the administrative assistant for your department.

Thank you!

Lisa Burns
 Benefits Coordinator
 City of Columbus

One final step if you did not 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

