

Common Census Employee Manual

State of New Hampshire



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Getting Started

You may access the system at: <http://admin.state.nh.us/hr/OnlineBenefits.html>

Been here before?
Enter your Account
Name and Password,
then click the Login
button. (If you have
forgotten your user
name or password,
contact your HR
representative

State of NH - TESTING

Existing User

Language: English US

Account Name:

Password:

Login | [I Forgot My Password...](#)

By clicking LOGIN, you accept the terms and conditions of Common Census, Inc.

[End User License Agreement](#) | [Privacy Policy](#) | [HIPAA Disclosure](#)

New User

In order to use Common Benefits® you need to create an account first and provide your password everytime you access it. We do this to protect your personal information.

[Create New Account](#)

Font Support Information | [Enabling International Support In Windows XP](#)

Recommended browsers: Internet Explorer 7 (or greater), Firefox 3 (or greater) or Chrome

powered by **Common Census** | **MyOwnBenefits**™

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Coach

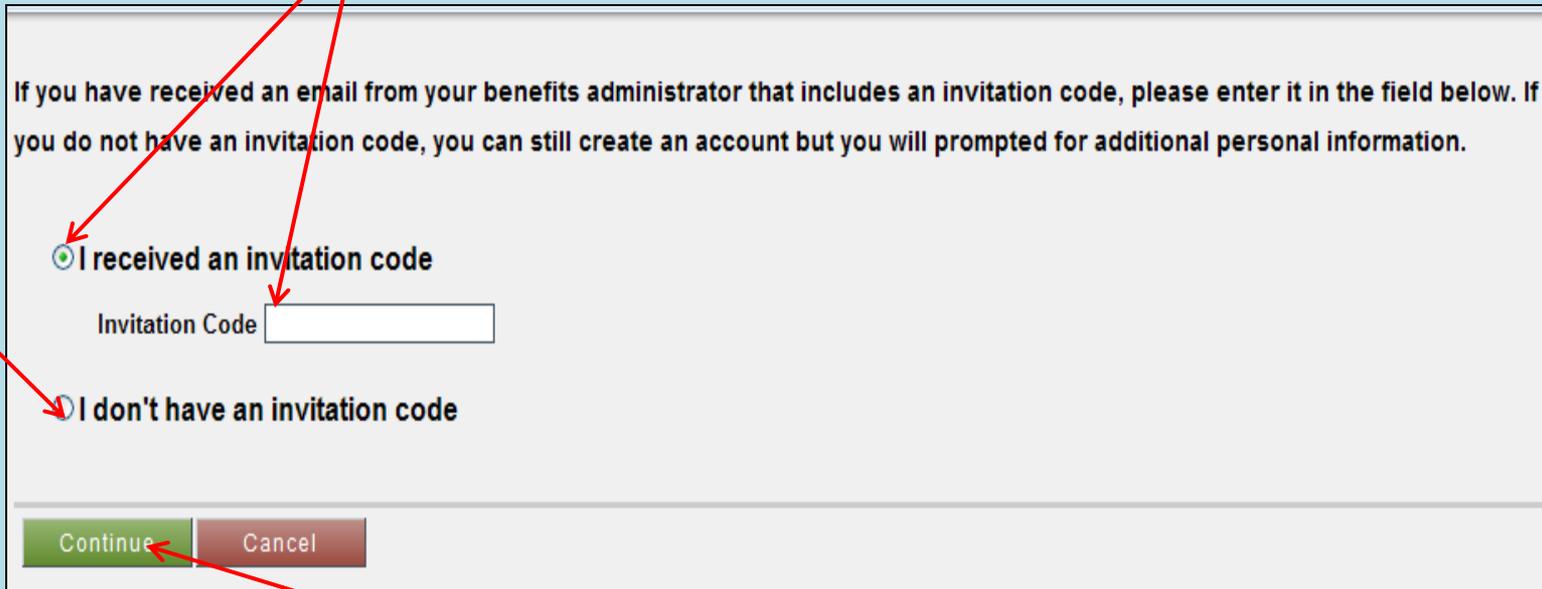
ebm

Your first time? Click the
“Create New Account”
button to get started.

Getting Started (Cont.)

If you have received an invitation code from your HR administrator, click “I received an invitation code” and enter the code in the box.

If you have NOT received an invitation code from your HR administrator, click “I don’t have an invitation code.”



If you have received an email from your benefits administrator that includes an invitation code, please enter it in the field below. If you do not have an invitation code, you can still create an account but you will be prompted for additional personal information.

I received an invitation code

Invitation Code

I don't have an invitation code

When finished, click the “Continue” button.

NOTE: During this open enrollment, the State will not be sending any invitation codes. Please select “I don’t have an invitation code” to proceed.

Getting Started (Cont.)

Please create your account by submitting the following information:

Last Name

Date of Birth

SSN

Enter in your personal information to verify your employment, then click continue.

Once you have verified your employment, you will be asked to **create** an Account Name (a login Name) and password. Enter your password, then confirm it by reentering in the "Confirm New Password" box.

Welcome Judy ,

Please select an account name and a password that will be used to authenticate you on this site:

Account Name

Password length is between 8 and 16 characters

New Password

Confirm New Password

When finished, click "Create Account." You will then be logged in to the system.

Welcome!

The Welcome page contains important information from the State. Please Scroll down and read the page completely. When you are finished, click “Continue”

State of NH - TESTING

Bolo F. AAATessss

Language: [English US](#) | [Account Management](#) | [Help](#) | [Sign Out](#)

[Messaging Center](#) | [Tools](#) | [PayChecker®](#)

IMPORTANT INFORMATION REGARDING OPEN ENROLLMENT AND NEW HIRE EVENTS

Welcome to your State of New Hampshire benefit enrollment system's 2011 Open Enrollment or New Hire event. Open Enrollment begins with a review of your and your dependent's personal information. If you are a newly hired employee, you will be enrolling yourself and your dependents (if applicable) using this system. In addition, you will be required to present verification of your dependents' eligibility (if applicable) with copies of birth certificates (for dependent children) and marriage licenses (for your spouse). Employee First Name, please carefully review and or complete the information requested. If you need assistance with enrolling in your benefits please contact your agency Human Resource (HR) representative. If you are unsure who to contact, please go to <http://admin.state.nh.us/hr/contacts.html> for an HR listing by agency.

NEW THIS YEAR

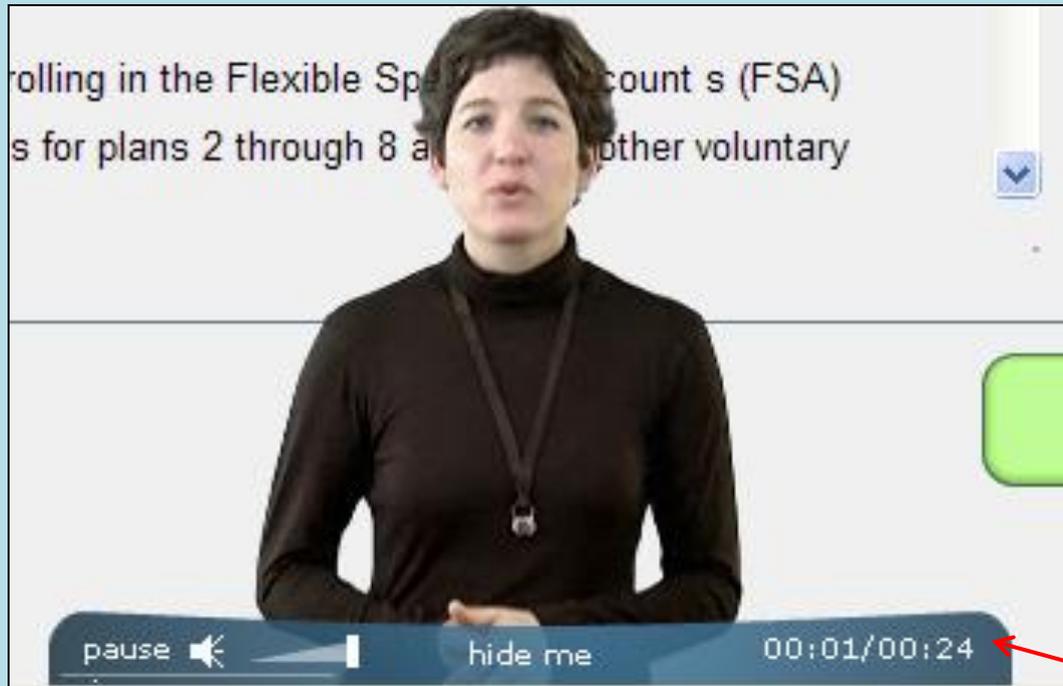
Enrollment in all benefit offerings is now available online! In addition to enrolling in the Flexible Spending Accounts (FSA) program, you now have the ability to sign up for the Life Insurance benefits for plans 2 through 8 as well as other voluntary

[Continue](#) →

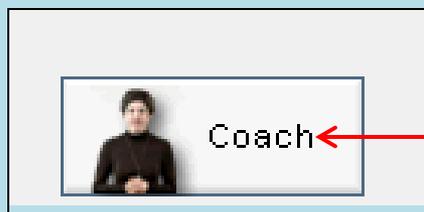
Coach

Live Coach

The Live Coach is available to help you with your enrollment. She will pop up on each page and give you instructions.



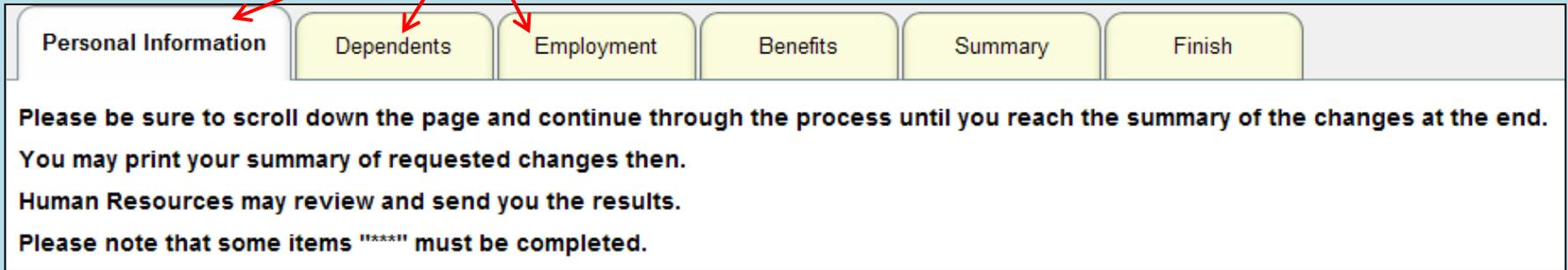
You can pause the coach, change the volume, hide her, rewind or replay her using the controls at the bottom



If you hide the coach, simply click on the "Coach" box at the bottom of the screen to show her.

Navigating the System

The system contains a series of tabs. Please review all of the information on each tab before moving to the next one.



A screenshot of the system's navigation interface. At the top, a horizontal row of seven tabs is shown: 'Personal Information', 'Dependents', 'Employment', 'Benefits', 'Summary', and 'Finish'. The 'Personal Information' tab is highlighted in light blue, while the others are light yellow. Three red arrows point from the text above to the 'Personal Information', 'Dependents', and 'Employment' tabs. Below the tabs, a white box contains the following text: 'Please be sure to scroll down the page and continue through the process until you reach the summary of the changes at the end. You may print your summary of requested changes then. Human Resources may review and send you the results. Please note that some items "****" must be completed.'

You may move to the next tab by hitting the "Continue" button.



A screenshot of the system's navigation interface. The 'Personal Information' tab is now highlighted in blue, while the other tabs ('Dependents', 'Employment', 'Benefits', 'Summary', 'Finish') are light yellow. A red arrow points from the text above to the 'Personal Information' tab.

You may only move forward to the next sequential tab. You may not skip any tabs. Once you have visited a tab it will turn blue. You may move backwards to any of the blue tabs at any time by clicking the tab name.

Your Personal Information

The “Personal Information” tab contains all of the demographic information for you that the State has on record. If any of it is incorrect, please notify your HR representative.

Personal Information Dependents Employment Benefits Summary Finish

Please be sure to scroll down the page and continue through the process until you reach the summary of the changes at the end. You may print your summary of requested changes then. Human Resources may review and send you the results. Please note that some items "****" must be completed.

First Name	Bolo	Phone	(205) 885-5885
Middle Initial	F	Mobile Phone	
Last Name***	AAATessss	E-Mail	
Date of Birth	05/01/1972		
Birth State			
Gender	Male		
SSN***	***_**_****		

Home Address

45 Marginal Way
Laconia
New Hampshire
05943
United States

Mailing Address

Report Life Event

Continue →

When you are finished reviewing the information, click the “Continue” button.

Your Dependents

Personal Information	Dependents	Employment	Benefits	Summary	Finish
▲ Marcia AAATessss Spouse Edit Delete					
Date of Birth	06/05/1978	Birth State	-	Home Address	...
Age	33	Phone		Full Time Student	
Gender	Female	E-Mail		Disabled	
SSN					
▲ Linda AAATessss Child Edit Delete					
Date of Birth	02/01/2011	Birth State	-	Home Address	, NH 50252, USA
Age	0	Phone		Full Time Student	
Gender	Female	E-Mail		Disabled	
SSN					
▲ Simon Bolo Child Edit Delete					
Date of Birth	10/13/2010	Birth State	-	Home Address	...
Age	1	Phone		Full Time Student	
Gender	Female	E-Mail	 Coach	Disabled	

The “Dependents” Tab shows the dependents that the system has on record. Review all of the dependents’ information. To edit a dependent, click the “Edit” button. To delete the dependent, click the “Delete” button.

Your Dependents

Edit the dependent information in the boxes. The yellow boxes are required fields.

Marcia AAATessss

Identification

Last Name***

First Name***

Middle Initial

SSN

Relationship

Date of Birth ***

Birth State

Gender

Full Time Student

Disabled

Financially Dependent

Contact Information

Use my address for this dependent

Address

City

State

Zip Code

Country

Phone

E-Mail

When finished, click the "Save" button.

Your Dependents

To add a dependent, click the “Add Dependent” button at the bottom of the page.

Simon Bolo Child Edit Delete

Date of Birth	10/13/2010	Birth State	-	Home Address	...
Age	1	Phone		Full Time Student	
Gender	Female	E-Mail		Disabled	
SSN	115-46-5452				

Add Dependent

Back Coach Continue

New Dependent

Identification

Last Name*** AAATessss

First Name***

Middle Initial

SSN

Relationship Child

Date of Birth***

Birth State

Gender Female

Full Time Student

Disabled

Financially Dependent

Contact Information

Use my address for this dependent

Phone (205) 885-5885

E-Mail

Save Cancel

Enter the dependent information in the boxes. The yellow boxes are required fields. When finished, click the “Save” button.

Please Note: Dependent eligibility verification documentation is required (e.g. birth certificate, marriage license, etc.) by the end of the enrollment period for coverage to be effective.

Your Employment

The “Employment” tab contains all of the employment information for you that the State has on record. If any of it is incorrect, please notify your HR representative.

Personal Information	Dependents	Employment	Benefits	Summary	Finish
Location	4401 - ENVIRONMENTAL SERVICES I	Compensation Type	Salaried		
Class	Active - FT	Compensation Frequency	Bi-Weekly		
Job Title	Supervisor	Avg. Hours/Week	39		
Occupation		Bi-Weekly Pay	**** **		
Hire Date	5/5/2004	Annual Compensation	** **** **		
Work Phone					
Work Email					

← Back

Continue →

When you are finished reviewing the information, click the “Continue” button.

Your Benefits

The “Benefits” tab, shows you all of the benefits you are eligible for.

Current Benefits

	Benefit Name	Start Date	End Date	Deduction Amount	Deduction Frequency
View/Modify	Medical 2012	01/01/2012	12/31/2012	\$80.00	Bi-Weekly

Declined Benefits

	Benefit Name	Decline Date
View/Modify	Dental 2012	12/01/2011
View/Modify	Medical FSA 2012	12/01/2011
View/Modify	Dependent FSA 2012	12/01/2011
View/Modify	Group Term Life	12/01/2011
View/Modify	Supplemental Term Life	12/01/2011

Available Benefits

 You must review all the benefits you are not enrolled in yet.
By clicking "continue" in the enrollments page you will be moving to the next benefit to be read about.

	Benefit Name
Review	Voluntary Group Short Term Disability
Review	Accident Plus (EAOP)
Review	CriticalAssistance® Plus

Current benefits shows you the benefits that you are currently enrolled in.

Declined benefits shows you the benefits that you have chosen to waive.

Available Benefits shows you the benefits that you are eligible for but not currently enrolled in.

Your Benefits

Terminated benefits shows you the benefits that you were previously enrolled in. You no longer have coverage in these benefits.

Terminated Benefits					
	Benefit Name	Start Date	End Date	Deduction Amount	Deduction Frequency
View/Modify	Group Term Life 2011	10/01/2011	09/28/2011		
View/Modify	Supplemental Term Life 2011	10/01/2011	09/28/2011		

Next to each benefit there is a button that allows you to see your benefit. The buttons are different based on your current status in that benefit.

“View” allows you to see a benefit but not edit it, based on your enrollment window.

“View/Modify” allows you to see and CHANGE a benefit that you are either currently enrolled in or have declined.

“Review” allows you to see and CHANGE a benefit that you are eligible for, but have not yet selected an enrollment status.

The screenshot shows the 'Available Benefits' section with a warning icon and text: 'You must review all the benefits you are r By clicking "continue" in the enrollments'. Below this, there is a table with columns for 'Benefit Name' and buttons for 'View', 'View/Modify', and 'Review'. The 'View' button is next to 'Dental 2012', 'View/Modify' is next to 'Existing STD Coverage', and 'Review' is next to 'Medical FSA 2011'. Red arrows point from the text blocks to these buttons.

Available Benefits	
View	Dental 2012
View/Modify	Existing STD Coverage
 You must review all the benefits you are r By clicking "continue" in the enrollments	
Benefit Name	
Review	Medical FSA 2011

Click on either “View/Modify” or “Review” to edit your benefit.

Your Benefits

When you click on the benefit, it will tell you your current enrollment status.

Bolo F. AAATessss :: Dental 2012

NOT ENROLLED [Return to List of Benefits](#)

Date Eligible 01/01/2012

[Enroll](#) [Decline](#)

Click the button “Enroll” to begin your enrollment. Click the “Decline” button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Return to List of Benefits.”

Your Benefits

When you click on the “Enroll” button, you become enrolled in the benefit.

Bolo F. AAATessss :: Dental 2012

ENROLLED

Effective Date 01/01/2012

State of New Hampshire

Covered Individuals

Bolo F. AAATessss (Self)

Semi-Monthly Contribution \$19.29

Not Covered Individuals

Employee

Pre-Tax Bi-Weekly Deduction \$0.00

Name (Relationship)	
Linda AAATessss (Child)	Add
Marcia AAATessss (Spouse)	Add
Simon Bolo (Child)	Add

Submit Cancel

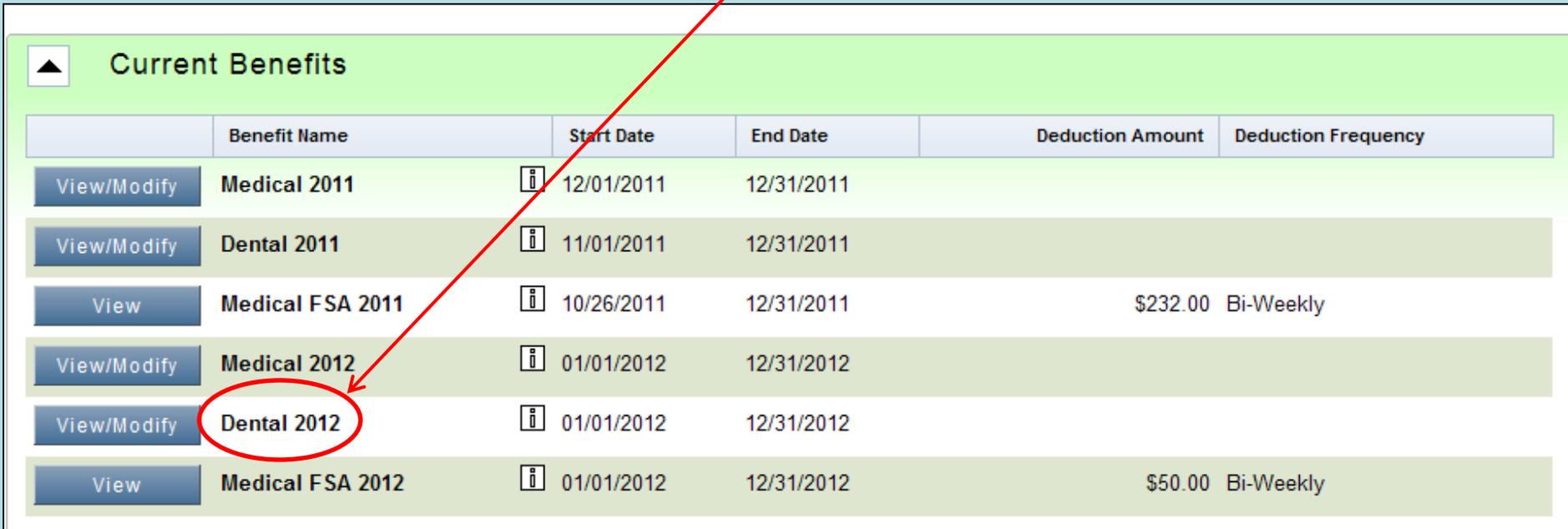
Your contribution amounts will automatically change when you add dependents.

You may add your eligible dependents.

When finished, click “Submit.”

Your Benefits

The benefit you enrolled will now show up under your Current Benefits



	Benefit Name	Start Date	End Date	Deduction Amount	Deduction Frequency
View/Modify	Medical 2011	 12/01/2011	12/31/2011		
View/Modify	Dental 2011	 11/01/2011	12/31/2011		
View	Medical FSA 2011	 10/26/2011	12/31/2011	\$232.00	Bi-Weekly
View/Modify	Medical 2012	 01/01/2012	12/31/2012		
View/Modify	Dental 2012	 01/01/2012	12/31/2012		
View	Medical FSA 2012	 01/01/2012	12/31/2012	\$50.00	Bi-Weekly

Your Benefits

Some of the benefits will have pop up videos to further explain the benefit.

The screenshot shows a video player interface. At the top left is the logo for "LIFE INSURANCE COMPANY OF BOSTON & NEW YORK". The main title of the video is "Why Accident Insurance? Because Accidents Do Happen!". On the left side, there is a table of contents:

Introduction	1 min. 2 sec.
Key Features	1 min. 25 sec
Financial Security	43 sec.
Get Cost Estimate >>	

The video content shows a woman in a business suit standing in front of a blurred background of a car's wheel and a road with yellow double lines. At the bottom of the player, there is a "pause" button, a progress bar showing "00:08/01:02", and a "continue" button with a play icon.

Your Benefits

Enrolling in Medical Coverage

Click the button “Enroll” or “Edit” (depending on your current enrollment status) to make a change to your benefit. Click the “Decline” button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Return to List of Benefits.”

A benefit description will give you more information about your plan. You may also click the link “Rx Plan Summary” to find out more information about your prescription drug coverage or the link “Anthem- How to Find Your Provider” to see instructions about searching for your PCP.

ENROLLED [Return to List of Benefits](#)

Effective Date	01/01/2012	State of New Hampshire	
Plan Type	POS	Semi-Monthly Contribution	\$985.28
Covered Individuals	Employee	Pre-Tax Bi-Weekly Deduction	\$60.00
EBM AAATest (Self)			
Child 1 AAATest (Child)			
Child 2 AAATest (Child)			
Not Covered Individuals			
AAATest, Spouse (Spouse)			

[Edit](#) [Decline](#)

Benefit Description & Associated Documents

The State of New Hampshire offers coverage in a Medical Plan through Anthem BCBS Medical. Please consult your Benefits Booklet located at: http://admin.state.nh.us/hr/open_enrollment.html or contact your Human Resources or Payroll Representative for full coverage information. If you choose to elect an HMO plan, you are required to choose a Primary Care Physician (PCP) for you and your family members (if applicable). If you choose to elect the POS plan, choosing a PCP is optional. If you do not have or do not know of a doctor you would like to pick for your PCP at this time, you can type in "Anthem" in the PCP field and Anthem will assign a PCP to you. To search for a Primary Care Physician (PCP) in Anthem's network or to get the PCP ID/Enrollment ID of your current PCP for your health benefit enrollment, you must go to Anthem.com to obtain the PCP ID/Enrollment ID assigned by Anthem. Follow the Steps in the "Anthem - How to Find Your Provider" document. If you are unable to find a provider using Anthem's web site, you can contact Anthem's State of New Hampshire dedicated line 1-800-933-8415 for assistance. Hours of operation are Mon-Thurs 8-8, Fri 8-5.

[Rx Plan Summary](#) [Anthem - How to Find Your Provider](#)

Your Benefits

Enrolling in Medical Coverage

Select either “HMO” or “POS” for the plan type.

You may add or remove your eligible dependents by clicking the “Add” button under “Not Covered Individuals” and the “Remove” button under “Covered Individuals”.

ENROLLED

Effective Date 01/01/2012

State of New Hampshire

Plan Type

HMO

POS

Semi-Monthly Contribution \$985.28

Employee

Pre-Tax Bi-Weekly Deduction \$60.00

Covered Individuals

EBM AAATest (Self)

Child 1 AAATest (Child) Remove

Child 2 AAATest (Child) Remove

Not Covered Individuals

Spouse AAATest (Spouse) Add

Continue Cancel

When finished, click the “Continue” Button

Your Benefits

Enrolling in Medical Coverage

Primary Care Physician(s)

Name (Relationship)	Provider Name	Provider Number
EBM AAATest (Self)	<input type="text"/>	<input type="text"/>
Child 1 AAATest (Child)	<input type="text"/>	<input type="text"/>
Child 2 AAATest (Child)	<input type="text"/>	<input type="text"/>

You are required to choose a Primary Care Physician (PCP) for you and your family members (if applicable) since you chose to elect an HMO plan. If you do not have or do not know of a doctor you would like to pick for your PCP at this time, you can type in "Anthem" in the PCP field and Anthem will assign a PCP to you.

To search for a Primary Care Physician (PCP) in Anthem's network or to get the PCP ID / Enrollment ID of your current PCP for your health benefit enrollment, you must go to Anthem.com to obtain the PCP ID / Enrollment ID assigned by Anthem. [Click here](#) for a step by step guide on how to obtain Anthem's PCP ID / Enrollment ID for your PCP.

If you are unable to find a provider using Anthem's web site, you can contact Anthem's State of New Hampshire dedicated line 1-800-933-8415 for assistance. Hours of operation are Mon-Thurs 8-8, Fri 8-5.

If you select an HMO, you will be required to fill in the PCP information for each person on the plan. Follow the instructions, if needed, to find your PCP information. Then click the "Submit" button.

Your Benefits

Enrolling in Dental Coverage

ENROLLED

Effective Date 01/01/2012

State of New Hampshire

Covered Individuals

EBM AAATest (Self)

Semi-Monthly Contribution \$18.98

Employee

Pre-Tax Bi-Weekly Deduction \$0.00

Not Covered Individuals

AAATest, Child 1 (Child)

AAATest, Child 2 (Child)

AAATest, Spouse (Spouse)

Edit Decline

Benefit Description & Associated Documents

The State of New Hampshire offers coverage in a Dental Plan through Northeast Delta Dental. Please consult your Benefits Booklet located at http://admin.state.nh.us/hr/open_enrollment.html or contact your Human Resources or Payroll Representative for full-coverage information.

 [Delta Dental Plan Summary](#)

Click the button “Enroll” or “Edit” (depending on your current enrollment status) to make a change to your benefit. Click the “Decline” button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Return to List of Benefits.”

A benefit description will give you more information about your plan. You may also click the link “Delta Dental Plan Summary” to find out more information about your plan.

Your Benefits

Enrolling in Dental Coverage

ENROLLED

Effective Date 01/01/2012

State of New Hampshire

Covered Individuals

Semi-Monthly Contribution \$36.32

EBM AAATest (Self)

Employee

Child 1 AAATest (Child)

Pre-Tax Bi-Weekly Deduction \$0.00

Not Covered Individuals

Name (Relationship)	
Child 2 AAATest (Child)	<input type="button" value="Add"/>
Spouse AAATest (Spouse)	<input type="button" value="Add"/>

You may add or remove your eligible dependents by clicking the “Add” button under “Not Covered Individuals” and the “Remove” button under “Covered Individuals”.

When finished, click the “Continue” Button

Your Benefits

Enrolling in Group Term Life Coverage

Click the button “Enroll” or “Edit” (depending on your current enrollment status) to make a change to your benefit. Click the “Decline” button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Return to List of Benefits.”

ENROLLED

Effective Date 01/01/2012

State of New Hampshire

Coverage Details

Semi-Monthly Contribution \$0.45

Employee Life Benefit Amount: \$20,000

Employee

[Return to List of Benefits](#)

[Edit](#) [Decline](#)

Benefit Description & Associated Documents

The State of New Hampshire provides you with a \$20,000 Basic Life Insurance benefit through Anthem Life. In addition, you have the opportunity to elect additional coverage in this plan. In the event you die from an accident, an amount equal to the Basic Life Insurance benefit will also be paid to your beneficiary. Please consult your Plan Certificate located at: http://admin.state.nh.us/hr/life_insurance.html or contact Anthem Life Insurance at 1-866-227-4005 for full coverage information. .

[Anthem Plan Summary](#)

A benefit description will give you more information about your plan. You may also click the link “Anthem Plan Summary” to find out more information about your plan.

Your Benefits

Enrolling in Group Term Life Coverage

Select the Life plan you would like to enroll in. Certain options will only be available to you if you have either a spouse or child listed as a dependent in the system. If you want to cover those individuals, please go back to the dependent screen and add them, then return to this benefit and enroll. When finished, click the “Continue” button.

Effective Date	01/01/2012	State of New Hampshire
Plan Selection		Semi-Monthly Contribution \$0.45
<input checked="" type="radio"/> Group Term Life		Employee
Employee Life Benefit Amount: \$20,000		Post-Tax Bi-Weekly Deduction \$0.00
<input type="radio"/> Group Term Life and AD&D		
Employee Life Benefit Amount: \$20,000		
Employee AD&D Benefit Amount: \$20,000		
<input type="radio"/> Group Term Life		
Employee Life Benefit Amount: \$25,000		
<input type="radio"/> Group Term Life and AD&D		
Employee Life Benefit Amount: \$25,000		
Employee AD&D Benefit Amount: \$25,000		
<input type="radio"/> Group Term Life and AD&D w/Dep Child(ren)		
Employee Life Benefit Amount: \$20,000		
Employee AD&D Benefit Amount: \$20,000		
Child(ren) Life Benefit Amount: \$3,000		
<input type="radio"/> Group Term Life and AD&D w/Dep Child(ren)		
Employee Life Benefit Amount: \$25,000		
Employee AD&D Benefit Amount: \$25,000		
Child(ren) Life Benefit Amount: \$3,000		
<input type="checkbox"/> Dependent Life Spouse		
Spouse Life Benefit Amount: \$10,000		

Your Benefits

Enrolling in Group Term Life Coverage

Beneficiaries

EBM AAATest (Self)

Primary Beneficiaries

Contingent Beneficiaries

Spouse AAATest (Spouse)

Primary Beneficiaries

Contingent Beneficiaries

Edit the beneficiary information for those covered by the plan(s) by clicking the button “View/Edit.” Edit both the Primary and Contingent beneficiary.

After you have finished editing you will be returned to this page. At that time, hit the “Submit” button to finish your enrollment.

Your Benefits

Enrolling in Group Term Life Coverage

EBM AAATest - Primary Beneficiaries

Designated Beneficiaries

Last Name	First Name	MI	Relationship	Percent	
Estate	Estate	Estate	Estate	10	
Smith	Joe		Employer	20	<input type="button" value="Remove"/>
Smith	Betty		Other	70	<input type="button" value="Remove"/>

Potential Beneficiaries

Last Name	First Name	MI	Relationship	Percent	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="10"/> %	<input type="button" value="Add"/>
AAATest	Child 1		Child	<input type="text" value="10"/> %	<input type="button" value="Add"/>
AAAtest	Child 2		Child	<input type="text" value="10"/> %	<input type="button" value="Add"/>
AAATest	Spouse		Spouse	<input type="text" value="10"/> %	<input type="button" value="Add"/>

Select one of the listed “Potential Beneficiaries” or write in a new one. You must complete all fields for the new beneficiary. Fill in the percent of the benefit you wish for that person to receive, with the total percents adding up to 100% for all of the beneficiaries. If you elect less than 100%, the remaining amount will default to your estate.

When finished, click the “OK” button.

Your Benefits

Enrolling in Supplemental Term Life Coverage

Click the button “Enroll” or “Edit” (depending on your current enrollment status) to make a change to your benefit. Click the “Decline” button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Return to List of Benefits.”

ENROLLED [Return to List of Benefits](#)

Effective Date 01/01/2012

State of New Hampshire

Coverage Details

Employee Life Benefit Amount:	\$100,000	Semi-Monthly Contribution	\$0.00
Employee AD&D Benefit Amount:	\$100,000	Employee	
Spouse Life Benefit Amount:	\$75,000	Post-Tax Bi-Weekly Deduction	\$9.97

[Edit](#) [Decline](#)

Benefit Description & Associated Documents

The State of New Hampshire provides you with a \$20,000 Basic Life Insurance benefit through Anthem Life. In addition, you have the opportunity to elect additional coverage in this plan. In the event you die from an accident, an amount equal to the Basic Life Insurance benefit will also be paid to your beneficiary. Please consult your Plan Certificate located at: http://admin.state.nh.us/hr/life_insurance.html or contact Anthem Life Insurance at 1-866-227-4005 for full coverage information. . If you are applying for a \$75,000 or \$100,000 benefit as an employee or a \$50,000, \$75,000 or \$100,000 benefit as a spouse of an employee, you will need to complete an Evidence of Insurability form and return it to the address provided on the form or fax it to the phone number listed in the top right corner of the form. Your deductions will not start until Anthem has approved your coverage. To view, download and print the form, Click the "Anthem Life EOI Form" link on the screen

[Anthem Plan Summary](#) [Anthem Life EOI Form](#)

A benefit description will give you more information about your plan. You may also click the link “Anthem Plan Summary” to find out more information about your plan or the link “Anthem Life EOI Form” which you will need to print and fill out for certain coverage elections.

Your Benefits

Enrolling in Supplemental Term Life Coverage

ENROLLED

Effective Date 01/01/2012

State of New Hampshire

Plan Selection

Life Plan 8

Employee Life Benefit Amount: \$100,000

Employee AD&D Benefit Amount: \$100,000

Spouse Life Benefit Amount: \$75,000

Spouse AD&D Benefit Amount: \$75,000

Semi-Monthly Contribution \$0.00

Employee

Post-Tax Bi-Weekly Deduction \$9.97

Continue Cancel

Select the “Employee Life Benefit Amount” and/or the “Spouse Life Benefit amount, then click “Continue”.

Note: If you are applying for a \$75,000 or \$100,000 benefit as an employee or a \$50,000, \$75,000 or \$100,000 benefit as a spouse of an employee, you will need to complete an Evidence of Insurability form and return it to the address provided on the form or fax it to the phone number listed in the top right corner of the form. Your deductions will not start until Anthem has approved your coverage.

Your Benefits

Enrolling in Supplemental Term Life Coverage

Beneficiaries

EBM AAATest (Self)

Primary Beneficiaries

Contingent Beneficiaries

Spouse AAATest (Spouse)

Primary Beneficiaries

Contingent Beneficiaries

Edit the beneficiary information for those covered by the plan(s) by clicking the button “View/Edit.” Edit both the Primary and Contingent beneficiary.

After you have finished editing you will be returned to this page. At that time, hit the “Submit” button to finish your enrollment.

Your Benefits

Enrolling in Supplemental Term Life Coverage

EBM AAATest - Primary Beneficiaries

Designated Beneficiaries

Last Name	First Name	MI	Relationship	Percent	
Estate	Estate	Estate	Estate	10	
Smith	Joe		Employer	20	Remove
Smith	Betty		Other	70	Remove

Potential Beneficiaries

Last Name	First Name	MI	Relationship	Percent	
<input type="text"/> 10 %	Add				
AAATest	Child 1		Child	10 %	Add
AAAtest	Child 2		Child	10 %	Add
AAATest	Spouse		Spouse	10 %	Add

OK

Select one of the listed “Potential Beneficiaries” or write in a new one. You must complete all fields for the new beneficiary. Fill in the percent of the benefit you wish for that person to receive, with the total percents adding up to 100% for all of the beneficiaries. If you elect less than 100%, the remaining amount will default to your estate.

When finished, click the “OK” button.

Your Benefits

Enrolling in a Medical FSA

Click the button “Enroll” or “Edit” (depending on your current enrollment status) to make a change to your benefit. Click the “Decline” or “Terminate” (depending on your current enrollment status) button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Close.”

A benefit description will give you more information about your plan. You may also click the link “FSA Worksheet” to assist you with your FSA election.

ENROLLED	
Eligibility Date	01/01/2012
Enrollment Date	12/07/2011
Effective Date	01/01/2012
Bi-Weekly Deduction	\$10.00

[Edit](#) [Terminate](#) [Close](#)

Benefit Description & Associated Documents

Your Medical FSA plan allows you to save money for eligible medical expenses. Please consult your **Benefits Booklet** located at http://admin.state.nh.us/hr/flexible_spending.html or contact **Combined Services** at 1-888-227-9745, Monday through Friday 8:00 a.m. to 4:30 p.m. or email flexiblebenefits@combinedservices.com if you have questions. Please Note: The payroll check deduction amounts displayed may not reflect the actual amounts deducted from an employee's paycheck. These amounts may vary, depending upon the start date of the deduction and/or whether the deduction commences after the first day of the calendar year. All deduction amounts should be independently verified for accuracy by the employee.

 [FSA Worksheet](#)

Your Benefits

Enrolling in a Medical FSA

ENROLLED

Plan Year 01/01/2012 to 12/31/2012
Date Eligible 01/01/2012
Enrollment Date 12/01/2011
Effective Date 01/01/2012

[FSA Calculator](#)

First Deduction Date 01/13/2012

Bi-Weekly Deferral (26 deductions left in Plan Year)

Total Deferral Amount

Elect the amount you would like in either the “Bi-Weekly Deferral” box or the “Total Deferral Amount” box. When you click elsewhere on the screen, the other box will automatically calculate for you. When finished, click the “Submit” button.

Your Benefits

Enrolling in a Dependent FSA

NOTE: Dependent FSAs are for dependent care expenses (i.e. daycare), NOT medical expenses

Click the button “Enroll” or “Edit” (depending on your current enrollment status) to make a change to your benefit. Click the “Decline” or “Terminate” (depending on your current enrollment status) button to decline the benefit. If you do not wish to change the status of the enrollment of this benefit right now, click the button “Close.”

The screenshot shows a web interface for enrolling in a dependent FSA. At the top left, there is a green bar with the word "ENROLLED" in white. Below this, a table lists the following details:

Eligibility Date	01/01/2012
Enrollment Date	12/01/2011
Effective Date	01/01/2012
Bi-Weekly Deduction	\$10.00

Below the table are three buttons: a green "Edit" button, a red "Terminate" button, and a grey "Close" button. Red arrows point from the "Close" button to the "Edit" and "Terminate" buttons. Below the buttons is a section titled "Benefit Description & Associated Documents" containing a paragraph of text. At the bottom left, there is a link labeled "FSA Worksheet" with a red arrow pointing to it.

ENROLLED

Eligibility Date 01/01/2012
Enrollment Date 12/01/2011
Effective Date 01/01/2012
Bi-Weekly Deduction \$10.00

Edit Terminate Close

Benefit Description & Associated Documents

Your Dependent Care FSA plan allows you to save money for eligible dependent care expenses. Please consult your Benefits Booklet located at http://admin.state.nh.us/hr/flexible_spending.html or contact Combined Services at 1-888-227-9745, Monday through Friday 8:00 a.m. to 4:30 p.m. or email flexiblebenefits@combinedservices.com if you have questions. Please Note: The payroll check deduction amounts displayed may not reflect the actual amounts deducted from an employee's paycheck. These amounts may vary, depending upon the start date of the deduction and/or whether the deduction commences after the first day of the calendar year. All deduction amounts should be independently verified for accuracy by the employee.

[FSA Worksheet](#)

A benefit description will give you more information about your plan. You may also click the link “FSA Worksheet” to assist you with your FSA election.

Your Benefits

Enrolling in a Dependent FSA

Elect the amount you would like in either the “Bi-Weekly Deferral” box or the “Total Deferral Amount” box. When you click elsewhere on the screen, the other box will automatically calculate for you. When finished, click the “Submit” button.

ENROLLED

Plan Year	01/01/2012 to 12/31/2012	
Date Eligible	01/01/2012	
Enrollment Date	12/01/2011	
Effective Date	01/01/2012	

[FSA Calculator](#)

First Deduction Date	01/13/2012	
Bi-Weekly Deferral	<input type="text" value="\$100.00"/>	(26 deductions left in Plan Year)
Total Deferral Amount	<input type="text" value="\$2,600.00"/>	

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

To enroll, click the button “Get Cost Estimate.” To decline click “I’m not interested”

Trustmark
Voluntary Benefit Solutions[®]
PERSONAL. FLEXIBLE. TRUSTED.

Return to Benefits

Trustmark Worksite Disability Income

Get Cost Estimate I'm not interested

Documents

[Group STD Plan Summary](#)

You will be prompted to answer two prerequisite questions. Select the correct answers, then click “Continue”

Trustmark
Voluntary Benefit Solutions[®]
PERSONAL. FLEXIBLE. TRUSTED.

Prerequisite Questions

Are you actively at work?

Yes No

Do you have any other Disability Income Insurance in force or applied for, excluding any employer paid plans?

Yes No

Continue → Cancel

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Other Insurance Details

You have answered Yes to the following question:
Do you have any other Disability Income Insurance in force or applied for, excluding any employer paid plans?

Documents

 [Group STD Plan Summary](#)

Please Provide Details

Name of Company	<input type="text"/>	
Benefit Amount	<input type="text"/>	<input type="radio"/> Week <input type="radio"/> Month
Benefit Period	<input type="text"/>	<input type="radio"/> Week <input type="radio"/> Month
Elimination Period	<input type="text"/>	



If you answered “Yes” to the question “Do you have any other Disability Income Insurance in force or applied for, excluding any employer paid plans?” you will be prompted to fill in additional information about that insurance. When you have filled in the required information, click the “Add” button.

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

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EBM AAATest - Insurance Quote

Weekly Benefit Amount

Please Select

Documents

[Group STD Plan Summary](#)

Back Continue Cancel

- Please Select
- \$670
- \$660
- \$650
- \$640
- \$630
- \$620
- \$610
- \$600
- \$590
- \$580
- \$570
- \$560
- \$550
- \$540
- \$530
- \$520
- \$510
- \$500
- \$490
- \$480
- \$470
- \$460
- \$450
- \$440
- \$430
- \$420
- \$410
- \$400
- \$390

First select the “Weekly Benefit Amount” you would like to receive. The available options are calculated based on your salary and plan rules.

Select the plan in which you would like to enroll. The premiums are calculated based on your selected “Weekly Benefit Amount” and plan rules.

When finished, click “Continue”

Weekly Benefit Amount

\$530

Plan

Elimination Period(s)	Benefit Period(s)	
	26 week(s)	52 week(s)
00 days / 07 days	<input checked="" type="radio"/> \$21.04	N/A
14 days / 14 days	N/A	<input type="radio"/> \$19.32

Back Continue

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

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Personal Information

Some required information for the applicant is missing, is incomplete or incorrect. Please enter or verify the information requested below before moving further.

Progress

Required Information

- Electronic Authorization
- Preview Application
- Applicant's Statements

Job Information

Job Title

Enter your “Job Title,” then click the “Continue” button.

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

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Progress

- Required Information
- Electronic Authorization**
- Preview Application
- Applicant's Statements

Documents

- [Group STD Plan Summary](#)

TRUSTMARK INSURANCE COMPANY
ACKNOWLEDGEMENT AND AUTHORIZATION TO OBTAIN INFORMATION

I authorize the entities listed in this authorization to give Trustmark, and through it, to its reinsurers and the Medical Information Bureau any data or records including pharmaceutical records that are individually identifiable in the entities possession about any proposed insureds or my mental or physical health. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; pharmacy; pharmacy benefit manager; MIB, Inc., formerly known as the Medical Information Bureau; or other organization, institution, or person which may have information about me or information pertinent to determine my eligibility for insurance as allowed or required by law. Information for consumers about MIB may be found at www.mib.com. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this authorization will be as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Trustmark. I understand that I may refuse to sign this authorization and still be assured treatment. Information disclosed under this authorization may be re-disclosed by recipient as permitted by law and may no longer be protected by HIPAA. (The person who signs this authorization may have a copy of it upon request.) If coverage cannot be issued as applied for, I authorize Trustmark to issue coverage on any insureds that are acceptable to Trustmark, to reduce benefits that are acceptable to Trustmark, and to adjust premiums to match the coverage issued. This authorization does not create any additional obligation by Trustmark to issue coverage to any proposed insured.

I acknowledge the application for life insurance on my life in the amount of \$

Name of Employee:

Name of Employer:

[← Back](#) [Continue →](#) [Cancel](#)

Read the Acknowledgement, then click the “Continue” button.

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

Group Name: State of New Hampshire | Group Number: G000018252 | Location: 404 - BUREAU OF GENERAL SERVICE

Applicant (Last, First, M.I.): AAATest, EBM | Male | Social Security No.: 111-22-3333 | Date of birth: 11/14/1975 | Date of marriage: _____

Spouse (Last, First, M.I.): _____ | Male | Social Security No.: _____ | Date of birth: _____ | Female

Date of hire: 01/01/1997 | Avg hours worked per week: 40 | Annual salary: 50000 | Occupation: Director | Applicant ID: _____

Have you or your spouse used tobacco products in the last year?
Applicant: No Yes | Spouse: No Yes | Home phone: 6035551212 | Work phone/ext.: (603) 555-3333

Home address: 123 South Street | City: Anytown | State: NH | Zip code: 03111

Child(ren) name: _____ | Date of birth: _____ | Full time student: Yes No
 Yes No

Primary Beneficiary: AAATest, Spouse (100%) | Relationship: Spouse
Contingent Beneficiary: _____ | Relationship: _____

Applicant will be the beneficiary for any spouse and/or child(ren) coverage

Payroll Mode: Weekly Bi-Weekly Semi-Monthly Monthly Other

I Am Applying For: Individual Single Parent Family Family

	Benefit Amount*	Premium Per Pay Mode*
Critical Illness Insurance	\$ 45,000	\$ 59.77
Plan (if applicable) CORE BENEFITS		
TOTAL PREMIUM		\$ 59.77

*If increasing coverage, enter the TOTAL Benefit Amount and Premium.

Eligibility Questions

1. Are you actively at work [on a full time basis] and able to perform the regular duties of your occupation?

Buttons: Back, Continue, Cancel

Next you will come to a copy of the application in which your information from this enrollment has been populated. You may print a copy for your records or simply click the “Continue” button.

Your Benefits

Enrolling in Voluntary Short Term Disability Coverage

Applicant's Statements

This application has been completed either by electronic or telephonic means, and I acknowledge that I have not myself actually signed the application but instead I hereby authorize Trustmark or its Agent to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes on this form. I acknowledge that Trustmark or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation.

I represent that all statements and answers given in this application are complete and true. I agree that all such statements and answers shall be made part of any insurance issued. Coverage may be provided under a policy issued to a trust. I hereby authorize Trustmark to issue lesser Disability Benefits than applied for if I am declined for the benefits I applied for. I authorize payroll deductions from my earnings for the amount necessary to pay any premiums due or past due. I further authorize any changes and adjustment in said deduction as may be necessary from time to time due to changes in age and/or rate increases. In the event coverage cannot be issued, Trustmark agrees this payroll deduction authorization will be void. **Acknowledgment** - I have received and read a copy of the Company's Notices about: 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices. **Trustmark is authorized to obtain an Investigative Consumer report on me. I understand that I may ask to be interviewed for this report.**

Authorization to Release Information - I authorize the entities listed herein to give Trustmark, and through it, to its reinsurers and the Medical Information Bureau any data or records in the entities possession about me or my mental or physical health. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility; insurance company; the Medical Information Bureau; or any other organization, institution, or person that has data on me or my health. This authorization is valid for two years and six months from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person who signs this form may have a copy of it upon request.)

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Applicant's Signature:

By clicking the 'Submit' button I agree:

- To apply my signature to this application/enrollment and all other documents that I have seen and reviewed during this enrollment session that require my signature.

Sign

Read the Applicant's Statement, then click the "Sign" button. After you have done so, your signature will be electronically acknowledged. Then click the "Submit" button to finish your enrollment.

Electronically Acknowledged

Back

Submit

Cancel

Back

Submit

Cancel

Your Benefits

Enrolling in Accident Plus (EAOP) Coverage



The screenshot shows a video player interface for Boston Mutual Life Insurance Company. The video title is "Features of the Boston Mutual Life Insurance Company Accident Insurance Coverage". The video is currently paused at 00:17/00:54. A woman is visible in the bottom left corner of the video frame. The video content lists the following features:

- Introduction 1 min.
- Get Cost Estimate** (with a play button icon)
- Key Features 59 sec.
 - Benefit Triggers for major and minor injuries
 - Ambulance Transfer, Emergency Room, Hospital confinement and Rehabilitation
- Additional Information 15 sec.
 - Accidental Death benefit

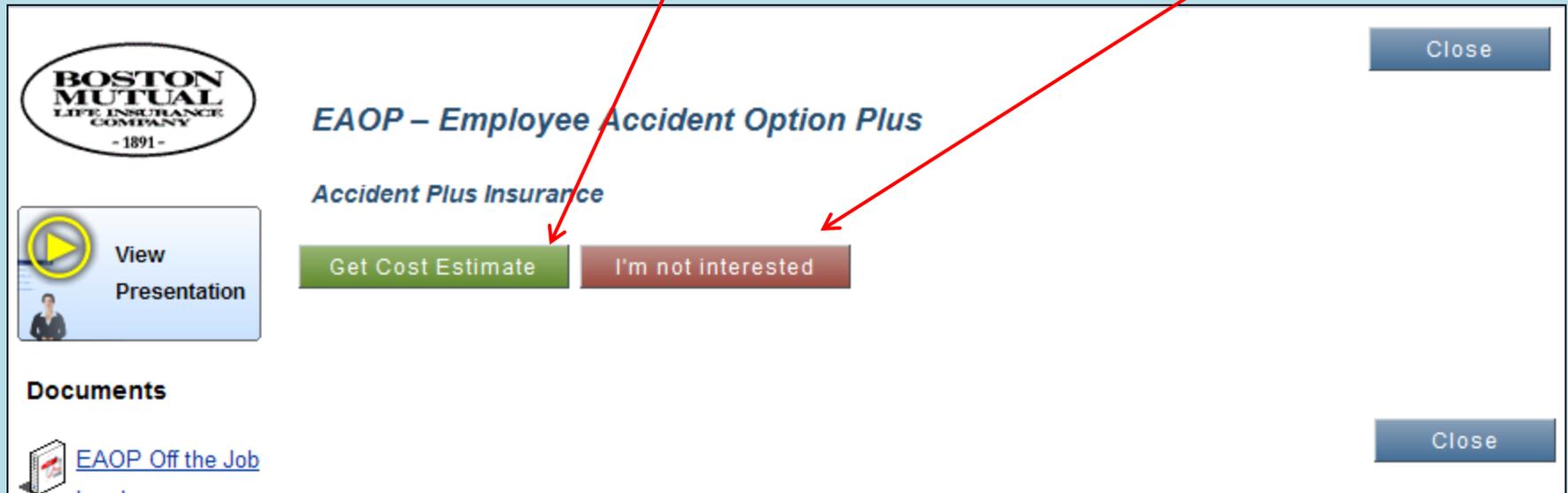
A red arrow points to a small "X" icon in the top right corner of the video player, indicating a close button. A green "continue" button is located at the bottom right of the video player.

When you enter the benefit, a video will pop up to give you more information on the benefit. You may close out of this video by clicking the "X" box in the top right corner.

Your Benefits

Enrolling in Accident Plus (EAOP) Coverage

To enroll, click the button “Get Cost Estimate.” To decline click “I’m not interested”



The screenshot displays the user interface for enrolling in EAOP coverage. On the left, the Boston Mutual Life Insurance Company logo is shown, along with a "View Presentation" button featuring a play icon and a small photo of a person. Below this is a "Documents" section with a link to "EAOP Off the Job". The main content area is titled "EAOP – Employee Accident Option Plus" and "Accident Plus Insurance". Two buttons are prominently displayed: a green "Get Cost Estimate" button and a red "I'm not interested" button. Red arrows point from the text above to these two buttons. In the top right and bottom right corners of the interface, there are blue "Close" buttons.

Your Benefits

Enrolling in Accident Plus (EAOP) Coverage

Select your Coverage Level, then add any additional Riders you would like for the plan. If you hover over the “i” next to the Riders with your mouse, additional information about the rider will pop up. When you have finished making your elections, click the “Continue” button

Coverage Selection

Date Of Birth: 11/14/1975 Age: 36

Coverage Level

Employee Only
 Employee / Spouse-Partner
 Employee / Children
 Employee / Spouse-Partner / Children

Base Plan
Base Plan Weekly Premium

Riders

Enhanced Emergency Room Benefit Rider ⓘ
 Enhanced Physician Office/Urgent Care Benefit ⓘ

Enhanced Physician Office/Urgent Care Treatment Benefit Rider
Pays an additional \$25 or \$50 benefit amount when an insured person requires initial examination and treatment by a Physician in a physician's office or urgent care facility. Treatment must be within 60 days of the covered accident and services provided must be the result of a covered accident and not routine examinations or preventative testing.

Total Deduction Amount \$10.76
of Deductions per year 26
Group Number 50371

Dependents

Child 1 AAATest (Child) **Eligible**
Child 2 AAATest (Child) **Eligible**
Spouse AAATest (Spouse) **Eligible**

[Add Dependent](#)

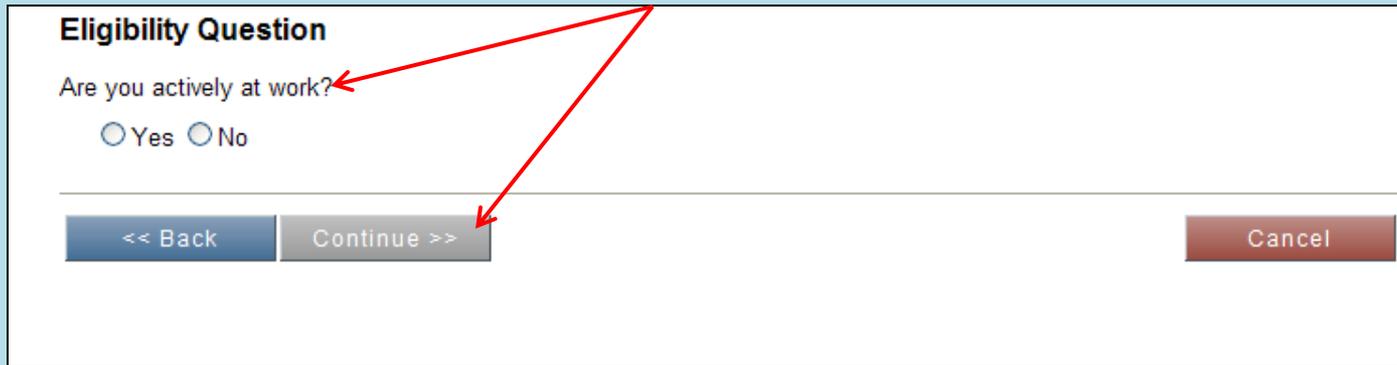
The premiums for this coverage are paid with pre-tax dollars, the benefits paid may be taxable to you. Please consult with your tax advisor.

[Continue >>](#) [Waive](#) [Cancel](#)

Your Benefits

Enrolling in Accident Plus (EAOP) Coverage

You will be prompted to answer an eligibility question. Select the correct answer, then click “Continue”



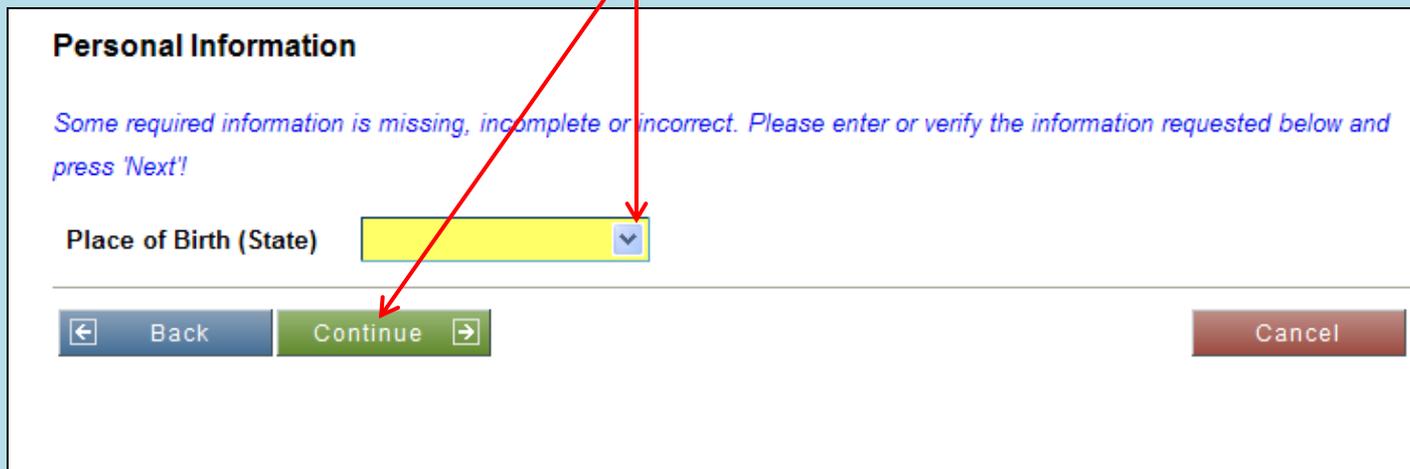
Eligibility Question

Are you actively at work?

Yes No

<< Back Continue >> Cancel

Enter your “Place of Birth,” then click the “Continue” button.



Personal Information

Some required information is missing, incomplete or incorrect. Please enter or verify the information requested below and press 'Next!'

Place of Birth (State)

← Back Continue → Cancel

Your Benefits

Enrolling in Accident Plus (EAOP) Coverage

You will be prompted to answer two prerequisite questions. Select the correct answers, then click “Continue”

Do you or any person to be insured have any accident insurance, excluding an employer's group plan, or any application for such insurance pending?

Yes No

Will this insurance replace any other coverage? (If yes, complete state replacement form if required)

Yes No

If "YES" to #1 OR #2, provide name of insurance company and type of insurance.

Company Name

Insurance Type

Special Requests:

If you answered “Yes” to either question, you will be prompted to fill in additional information about that insurance. When you have filled in the required information, click the “Continue” button.

Your Benefits

Enrolling in Accident Plus (EAOP) Coverage

Primary Beneficiary(ies)

Designated beneficiaries

Full Name	Relationship	Age	Percent	
<<None>>				

Potential beneficiaries

Full Name	Relationship	Age	Percent	
<input type="text"/>	<input type="text"/>	<input type="text"/>	100 %	<input type="button" value="Add"/>
AAATest, Child 1	Child	21	100 %	<input type="button" value="Add"/>
AAAtest, Child 2	Child	20	100 %	<input type="button" value="Add"/>
AAATest, Spouse	Spouse	31	100 %	<input type="button" value="Add"/>
Estate			100 %	<input type="button" value="Add"/>
Equally Among Children			100 %	<input type="button" value="Add"/>

Select one of the listed “Potential Beneficiaries” or write in a new one. You must complete all fields for the new beneficiary. Fill in the percent of the benefit you wish for that person to receive, with the total percents adding up to 100% for all of the beneficiaries. When finished, click the “Continue” button.

Your Benefits

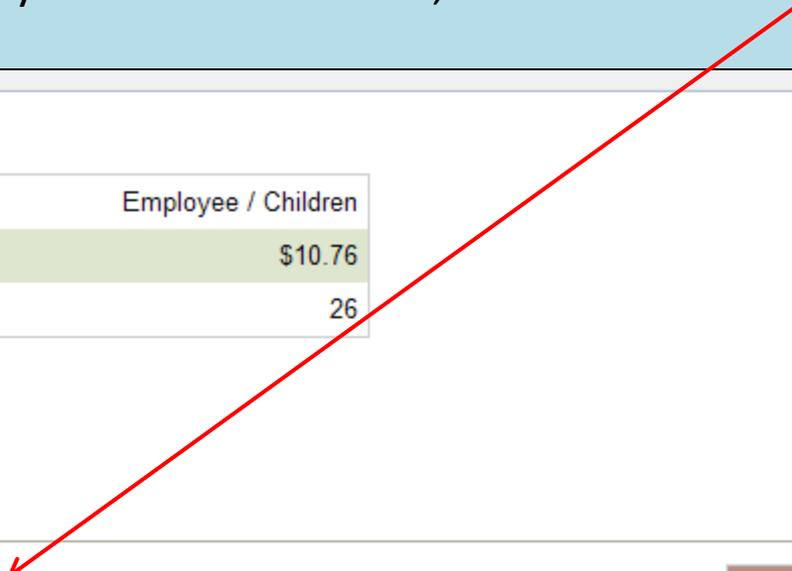
Enrolling in Accident Plus (EAOP) Coverage

You will be brought to a Summary of Elections. Review, then click the “Continue” button.

Summary of Elections

Coverage Level	Employee / Children
Total Deduction Amount	\$10.76
# of Deductions per year	26

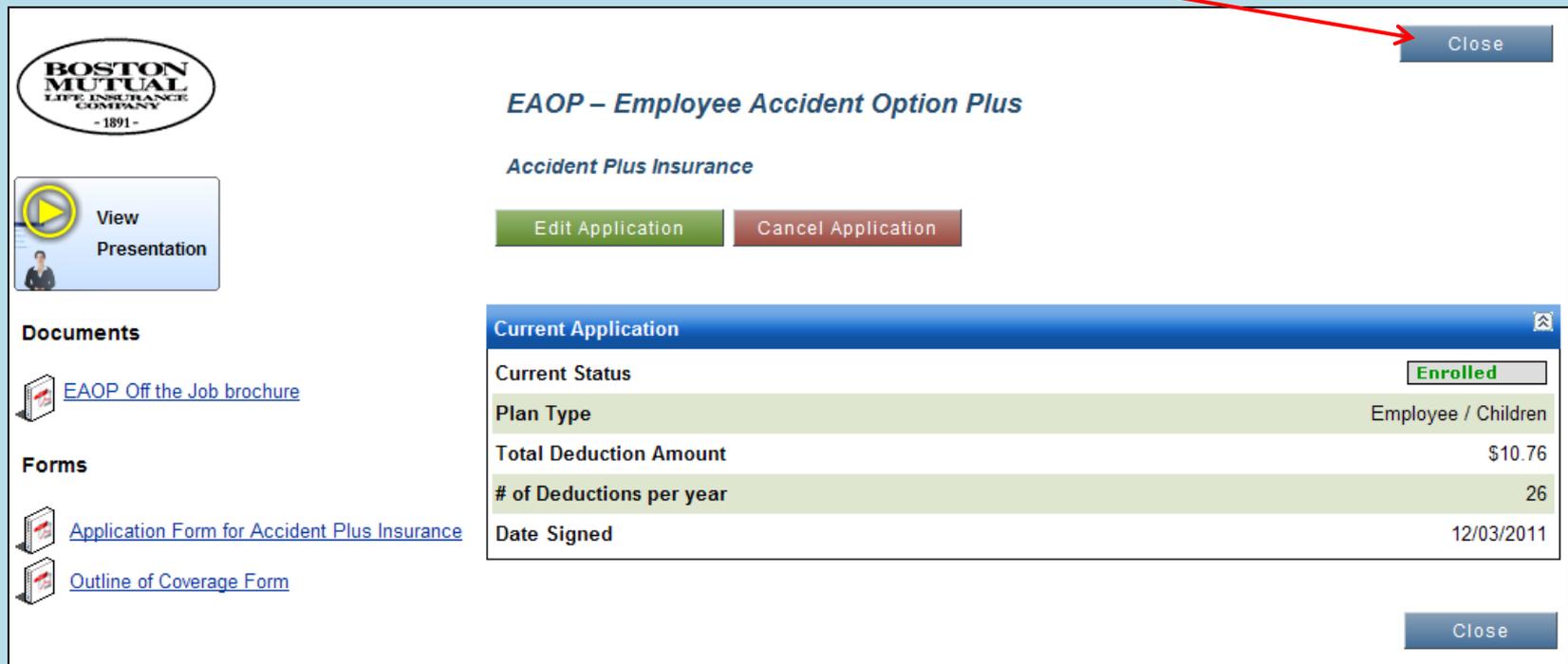
<< Back Continue >> Cancel



Your Benefits

Enrolling in Accident Plus (EAOP) Coverage

You will be brought to a page with information about your enrollment status. To exit, click the “Close” button.



BOSTON MUTUAL
LIFE INSURANCE COMPANY
- 1891 -

 **View Presentation**

Documents

-  [EAOP Off the Job brochure](#)

Forms

-  [Application Form for Accident Plus Insurance](#)
-  [Outline of Coverage Form](#)

EAOP – Employee Accident Option Plus

Accident Plus Insurance

[Edit Application](#) [Cancel Application](#)

Current Application

Current Status	Enrolled
Plan Type	Employee / Children
Total Deduction Amount	\$10.76
# of Deductions per year	26
Date Signed	12/03/2011

[Close](#)

Your Benefits

Enrolling in Critical Assistance Plus Coverage

TRANSAMERICA
LIFE INSURANCE COMPANY

The Need for Critical Illness Insurance

Did you realize that 62% of all bankruptcies were caused by health problems?*

Critical Illness insurance is a specialized product designed to provide financial protection for you and your family when you need it most.

The insurance pays in addition to group major medical or Medicare and is paid directly to the insured or whomever he or she chooses.

This benefit can provide protection when a critical illness occurs and expenses mount.

*Kelly, Matt. 62% of Bankruptcies Caused by Health Problems - What Can You Do?, Business Week, July 28, 2009.

Introduction 49 sec.
Key Features 1 min. 22 sec.
Financial Strength 30 sec.
Additional Information 12 sec.
Get Cost Estimate >>

00:25/00:49

continue ▶

When you enter the benefit, a video will pop up to give you more information on the benefit. You may close out of this video by clicking the “X” box in the top right corner.

Your Benefits

Enrolling in Critical Assistance Plus Coverage

To enroll, click the button “Get a quote.” To decline click “I’m not interested”

TRANSAMERICA

TRANSAMERICA® CriticalAssistance® Plus

Group Critical Illness Insurance

View Presentation

Get a quote

I'm not interested

Return to Benefits

You will be prompted to answer two eligibility questions. Select the correct answers, then click “Continue”

TRANSAMERICA

Employee's Eligibility

Are you actively at work [on a full time basis] and able to perform the regular duties of your occupation? If “No”, you and your dependents are not eligible for coverage.

Yes No

Occupation

Continue

Cancel

Your Benefits

Enrolling in Critical Assistance Plus Coverage



Please read the following information carefully.

- *This is an electronic enrollment and application process that enables you to elect your benefits and apply electronically for insurance product(s) underwritten by Transamerica Life Insurance Company. You are not obligated to use this process.*
- *At the end of each electronic enrollment, you will be asked to review the application for accuracy and enter your employer provided Personal Identification Number ("PIN") to complete the transaction.*
- *Entering your PIN and clicking the "Sign and Submit Application" button will constitute your signature on the application and any other required form.*
- *If for any reason you do not wish to complete an electronic application, you have the right to submit a paper application. You can stop the electronic enrollment process at any time.*

To continue with this electronic enrollment, please click the "I Agree" button below.

I Agree

Cancel

Read the information about the electronic enrollment, then click the button "I Agree."

Your Benefits

Enrolling in Critical Assistance Plus Coverage

Answer the tobacco use questions and select the Benefit Amount and the Coverage Level. When you are finished, click the "Continue" button.

TRANSAMERICA

Have you used tobacco products in the last year?
 Yes No

Package Details

Category 1 Benefits	Included
Category 2 Benefits	Included
Category 3 Benefits	Included

Benefit Amount: \$45,000

Coverage Level

Individual
 Single Parent Family
 Family

Riders

Wellness Buy-Up Rider
Monthly Benefit Amount \$50

Has your Spouse used tobacco products in the last year?
 Yes No

NOTE: To be eligible for coverage, children must be unmarried and be dependent upon the employee for support. Children include natural children, adopted children and children for whom adoption proceedings have begun, stepchildren who live with the employee, children for whom the employee has been appointed legal guardian and lives with the employee, grandchildren, foster children and children not living with the employee but for whom the employee is legally required to provide support.

<< Back Continue >> Cancel

Premium Amount	\$85.50
Deduction Frequency	26
Issue Type	Simplified Issue

Your Benefits

Enrolling in Critical Assistance Plus Coverage

Eligibility Questions

Is any proposed insured covered by any Title XIX program (e.g. Medicaid)?

Yes No

<< Back Next >> Cancel

Eligibility Questions (Continuation)

Employee

Height 5' 6"

Weight 131 pounds

Has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease?

Yes No

In the ten years prior to the application date, has any proposed insured been treated for, been diagnosed as having, or had any indication, sign, or symptom of having any heart (including heart attack), lung, brain, circulatory, respiratory, blood, vascular (including stroke), neurological, kidney, liver, pancreas, rheumatoid, or reproductive disorders, diabetes, optic neuritis, fibromyalgia, or chronic fatigue syndrome, had any medical or surgical procedures recommended (including major organ transplant) or advised by a physician but not done at this time, or, in the two years prior to the application date, been treated or counseled for alcohol or drug abuse?

Yes No

Does any proposed insured have high blood pressure that is controlled by more than two medications?

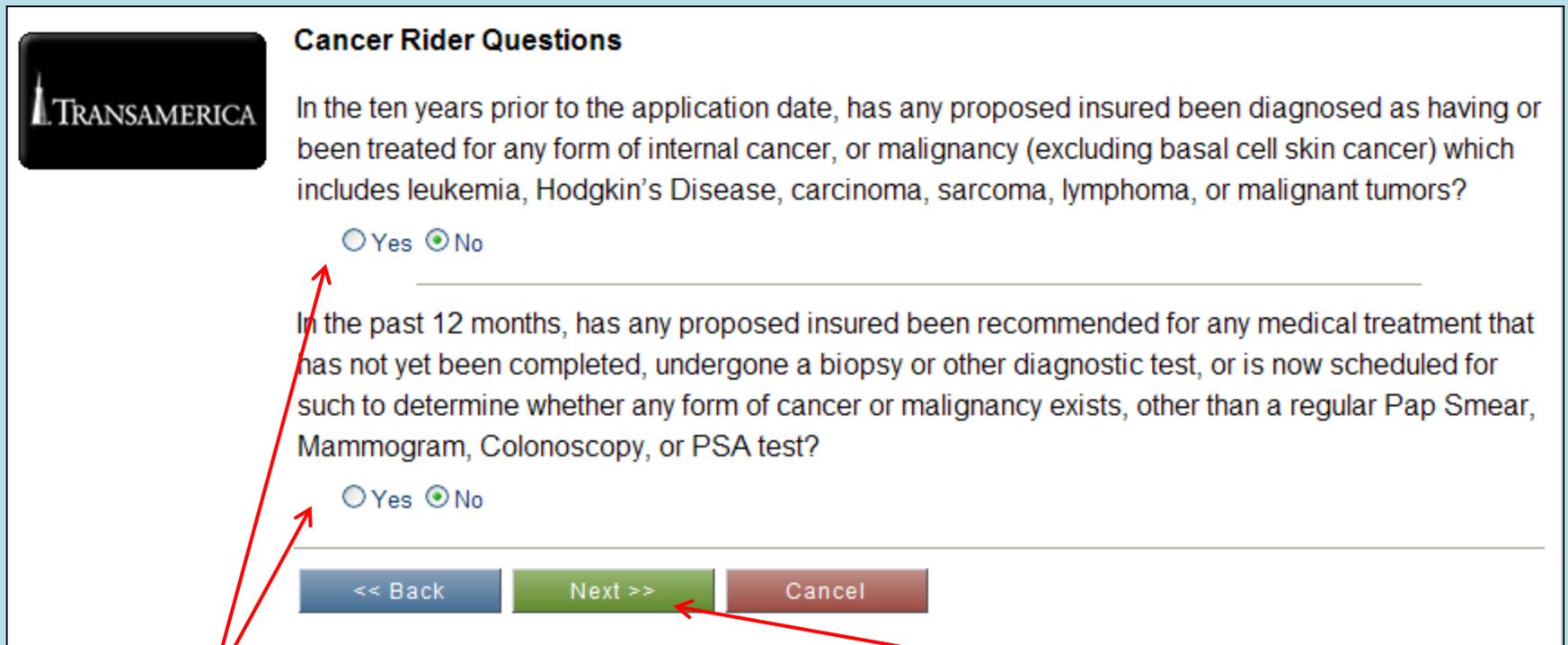
Yes No

<< Back Next >> Cancel

You will be prompted through a series of eligibility questions. Answer all of the questions, then click "Next"

Your Benefits

Enrolling in Critical Assistance Plus Coverage



The screenshot shows a web form titled "Cancer Rider Questions" with the Transamerica logo in the top left. The form contains two questions, each with radio button options for "Yes" and "No". The "No" option is selected for both. At the bottom, there are three buttons: "<< Back" (blue), "Next >>" (green), and "Cancel" (red). Red arrows point from the "Next >>" button to the text below the form.

TRANSAMERICA

Cancer Rider Questions

In the ten years prior to the application date, has any proposed insured been diagnosed as having or been treated for any form of internal cancer, or malignancy (excluding basal cell skin cancer) which includes leukemia, Hodgkin's Disease, carcinoma, sarcoma, lymphoma, or malignant tumors?

Yes No

In the past 12 months, has any proposed insured been recommended for any medical treatment that has not yet been completed, undergone a biopsy or other diagnostic test, or is now scheduled for such to determine whether any form of cancer or malignancy exists, other than a regular Pap Smear, Mammogram, Colonoscopy, or PSA test?

Yes No

<< Back Next >> Cancel

Answer the Cancer Rider Questions, then click the "Next" button

Your Benefits

Enrolling in Critical Assistance Plus Coverage

AAATest, EBM (Self) - Primary Beneficiary(ies)

Designated beneficiaries

Last Name	First Name	MI	Relationship	Percent	
AAATest	Spouse		Spouse	100%	Remove

Possible beneficiaries

Last Name	First Name	MI	Relationship	Percent	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> %	Add
All legal children of the insured, share and share alike				<input type="text"/> %	Add
Estate				<input type="text"/> %	Add
AAATest	Child 1		Child	<input type="text"/> %	Add
AAATest	Child 2		Child	<input type="text"/> %	Add

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

Select one of the listed “Possible Beneficiaries” or write in a new one. You must complete all fields for the new beneficiary. Fill in the percent of the benefit you wish for that person to receive, with the total percents adding up to 100% for all of the beneficiaries. When finished, click the “Continue” button.

Your Benefits

Enrolling in Critical Assistance Plus Coverage

You will be brought to a Summary of Elections. Review, then click the “Continue” button.

Summary of Elections

TRANSAMERICA

Name	Relationship	Status	Coverage Level	Ded. Amount
EBM AAATest	Self	Enrolled	Individual	\$59.77
Total Deduction Amount				\$59.77
Deduction Frequency				26

← Back Continue → Cancel

Your Benefits

Enrolling in Critical Assistance Plus Coverage

TRANSAMERICA

Group Name: State of New Hampshire Group Number: G000018252 Location: 404 - BUREAU OF GENERAL SERVICE

Applicant
(Last, First, M.I.): AAATest, EBM Male Social Security No.: 111-22-3333 Date of birth: 11/14/1975 Date of marriage: _____
 Female

Spouse
(Last, First, M.I.): _____ Male Social Security No.: _____ Date of birth: _____
 Female

Date of hire: 01/01/1997 Avg hours worked per week: 40 Annual salary: 50000 Occupation: Director Applicant ID: _____

Have you or your spouse used tobacco products in the last year?
Applicant: No Yes Spouse: No Yes Home phone: 6035551212 Work phone/ext.: (603) 555-3333

Home address: 123 South Street City: Anytown State: NH Zip code: 03111

Child(ren)
Name: _____ Date of birth: _____ Full time student: Yes No Name: _____ Date of birth: _____ Full time student: Yes No
 Yes No Yes No

Primary Beneficiary:
(Last, First, M.I.): AAATest, Spouse (100%) Relationship: Spouse

Contingent Beneficiary:
(Last, First, M.I.): _____ Relationship: _____

Applicant will be the beneficiary for any spouse and/or child(ren) coverage

Payroll Mode: Weekly Bi-Weekly Semi-Monthly Monthly Other _____

I Am Applying For: Individual Single Parent Family Family

	Benefit Amount*	Premium Per Pay Mode*
Critical Illness Insurance Plan (if applicable) CORE BENEFITS	\$ 45,000	\$ 59.77
*If increasing coverage, enter the TOTAL Benefit Amount and Premium.		TOTAL PREMIUM \$ 59.77

Eligibility Questions

1. Are you actively at work [on a full time basis] and able to perform the regular duties of your occupation? Yes No

Back Continue Cancel

Next you will come to a copy of the application in which your information from this enrollment has been populated. You may print a copy for your records or simply click the “Continue” button.

Your Benefits

Enrolling in Critical Assistance Plus Coverage

Deduction Amount	\$59.77
# of Deductions per year	26

[Change Elections](#)

Did you receive an Outline of Coverage describing the Insurance you are applying for, which is required?
 Yes No

I have read or had read to me the completed application.

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work on the effective date (according to the insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

I understand that the insurance I am applying for contains a Pre-Existing Condition Limitation and that pre-existing conditions will not be covered for the period stated in the certificate.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I understand the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below. I understand that a person to be covered for specified disease insurance cannot also be covered by any Title XIX Program (Medicaid).

Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Insurer, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

By entering my PIN below, I agree to submit my application to Transamerica Life Insurance through this electronic process.

Last 4 Digits of your SSN

Month & Day of your Birth
Date (MM/DD)

Mother's Maiden Name

[<< Back](#) [Accept](#) [Cancel](#)

Read the agreement, then sign the application by entering a PIN at the bottom of the page. This PIN is made up of different verification pieces; the last 4 digits of your SSN, the month and day of your birth and your mother's maiden name. Once you have filled these in, click the "Accept" button.

Your Summary

When you have finished your enrollment, you will be brought to a summary page that will show you a synopsis of all of your information. You may click the “Edit” button in each section to go back to the corresponding tab.

The screenshot shows a web interface for an enrollment summary. At the top, there are navigation tabs: Personal Information, Dependents, Employment, Benefits, Summary (highlighted), and Finish. Below the tabs, a message reads: "Please scroll down and review your selections, making any edits necessary. Then continue to the next and final step." To the right of this message is a link "Get Printer Friendly Version" with a printer icon. Below the message is a section titled "Personal Information" with an expand/collapse arrow on the left. This section contains two columns of information. The left column lists: First Name (Bolo), Last Name (AAATessss), Middle Initial (F), SSN (999-00-8858), Date of Birth (05/01/1972), Birth State, Gender (Male), and Phone ((205) 885-5885). The right column is titled "Home Address" and lists: Address (45 Marginal Way), City (Laconia), State / Zip Code (New Hampshire / 05943), and Country (United States). Below the Home Address is a "Mailing Address" section with the text "Use Home Address as Mailing Address". An "Edit" button is located at the top right of the Personal Information section. A red arrow points from the "Edit" button in the text above to this button in the screenshot.

Personal Information	
First Name	Bolo
Last Name	AAATessss
Middle Initial	F
SSN	999-00-8858
Date of Birth	05/01/1972
Birth State	
Gender	Male
Phone	(205) 885-5885
Mobile Phone	

Home Address	
Address	45 Marginal Way
City	Laconia
State / Zip Code	New Hampshire / 05943
Country	United States

Mailing Address
Use Home Address as Mailing Address

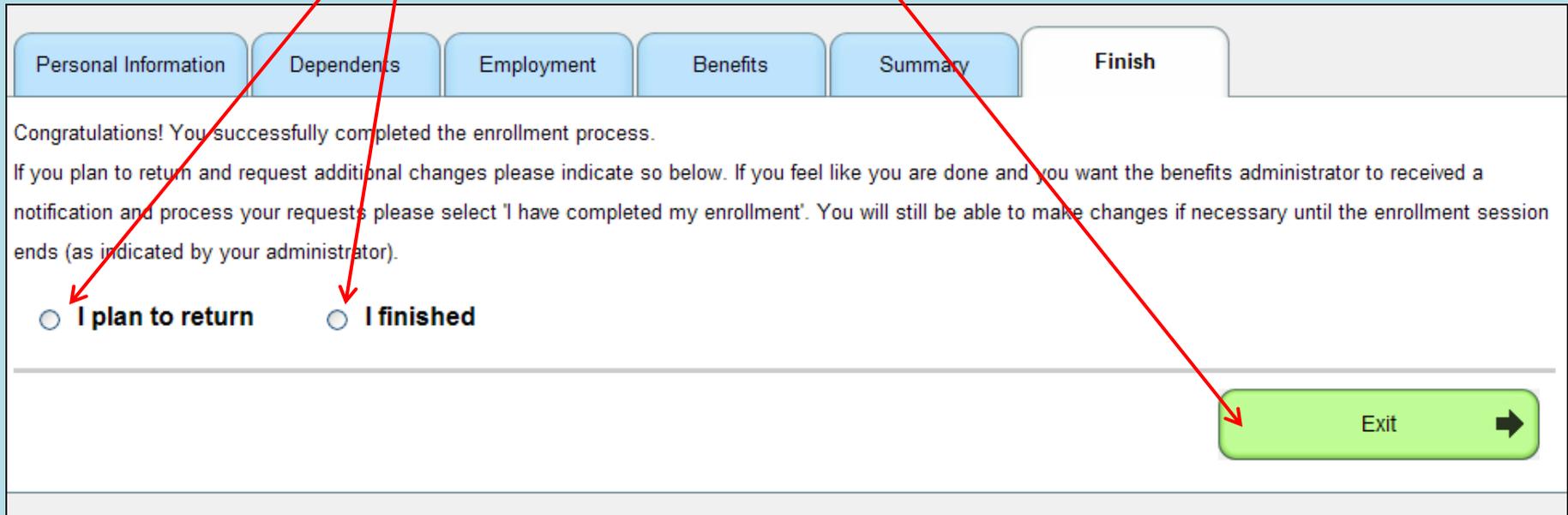
You may print out your requested changes by clicking the link “Get Printer Friendly Version” on this page. This will show your REQUESTS, not your enrolled coverage.

Review the entire summary page.
When you are finished, click
“Continue.”



Finishing Your Enrollment

After reviewing all other tabs, you will be brought to the “Finish” tab. If you are not ready to submit your changes, click “I plan to return.” If you are ready to submit your changes, click “I finished.” Clicking exit will log you out of the system.



Personal Information Dependents Employment Benefits Summary **Finish**

Congratulations! You successfully completed the enrollment process.

If you plan to return and request additional changes please indicate so below. If you feel like you are done and you want the benefits administrator to received a notification and process your requests please select 'I have completed my enrollment'. You will still be able to make changes if necessary until the enrollment session ends (as indicated by your administrator).

I plan to return **I finished**

Exit →

Return to the System

IMPORTANT INFORMATION REGARDING OPEN ENROLLMENT AND NEW HIRE EVENTS

Welcome to your State of New Hampshire benefit enrollment system's 2011 Open Enrollment or New Hire event. Open Enrollment begins with a review of your and your dependent's personal information. If you are a newly hired employee, you will be enrolling yourself and your dependents (if applicable) using this system. In addition, you will be required to present verification of your dependents' eligibility (if applicable) with copies of birth certificates (for dependent children) and marriage licenses (for your spouse). EBM, please carefully review and or complete the information requested. If you need assistance with enrolling in your benefits please contact your agency Human Resource (HR) representative. If you are unsure who to contact, please go to <http://admin.state.nh.us/hr/contacts.html> for an HR listing by agency.

NEW THIS YEAR

Enrollment in all benefit offerings is now available online! In addition to enrolling in the Flexible Spending Accounts (FSA) program, you now have the ability to sign up for the Life Insurance benefits for plans 2 through 8 as well as other voluntary benefits (such as short-term disability, critical illness and accident insurance) through the State of New Hampshire benefit enrollment system. In addition, during the fall 2011 Open Enrollment event, you will have the opportunity to enroll in the State of New Hampshire Health Plan.

Review from the beginning Review enrollment from last confirmed step

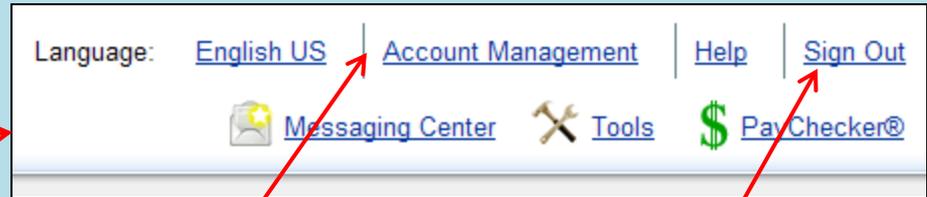
 Coach



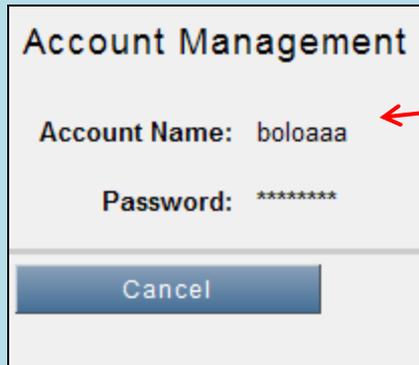
When you return to the system, you will have the option of starting your enrollment from the beginning or returning to where you left off. Click either “Review from the beginning” or “Review enrollment from last confirmed step,” then click “Continue.”

Your Tools

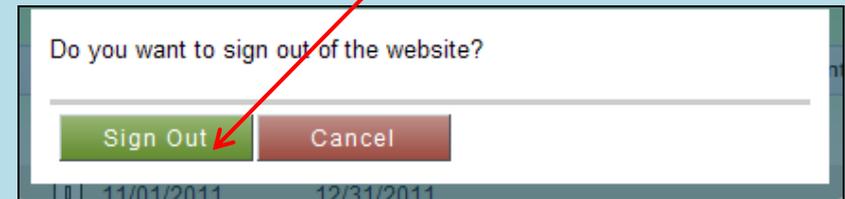
The tools in the top right hand corner are here to assist you with your enrollment.



“Sign Out” allows you to exit the system. You may restart next time from where you have left off.



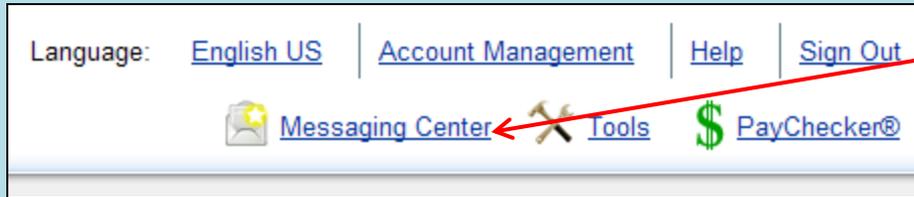
“Account Management” allows you to verify your User Name. To change your user name and password, contact your HR representative.



“Tools” links you to your Benefit Statement and Financial Calculators.



Messaging



“Messaging Center” allows you to view and send messages.



Contact Your Benefits Administrator

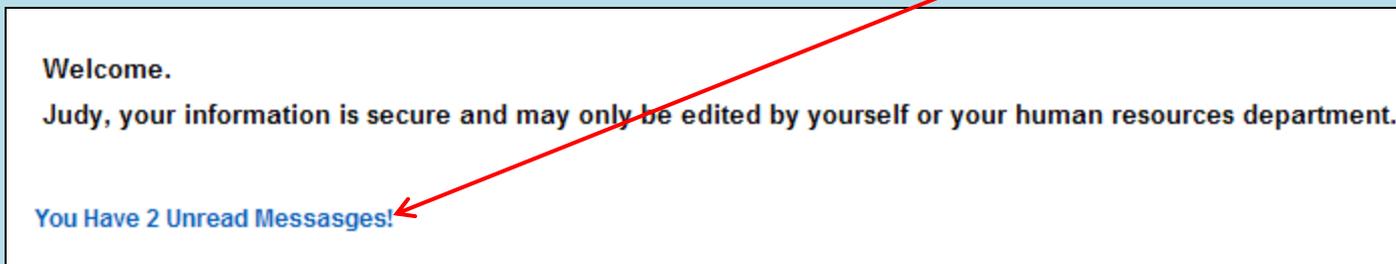
Subject
FSA

Message
What is the difference between the medical and dependent FSA?

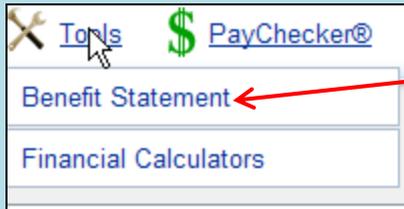
[Send](#) [Cancel](#)

Type the message subject in the “Subject” box, then the message text in the “Message” box. Hit “Send” to send the message to the HR Administrator.

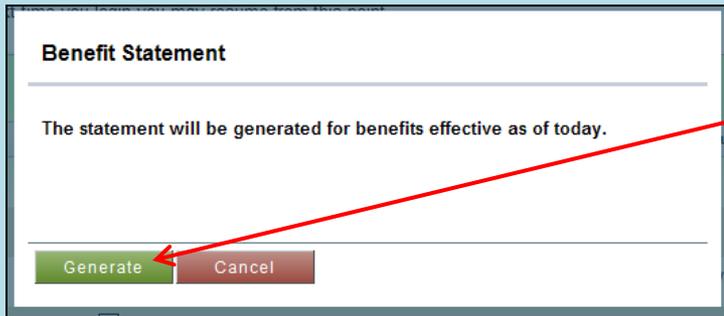
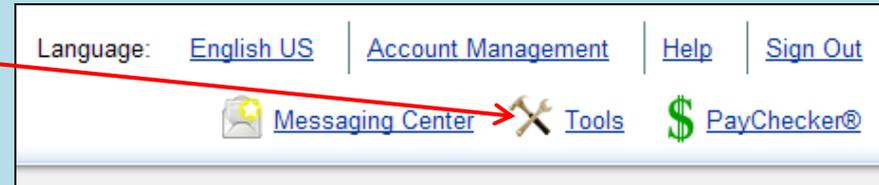
When you have a message from your administrator, it will appear as you log in.



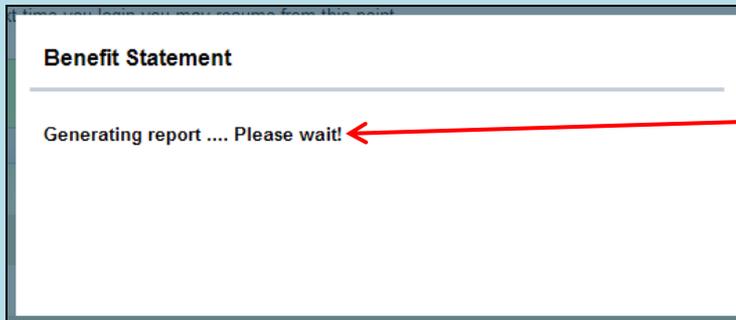
Your Benefit Statement



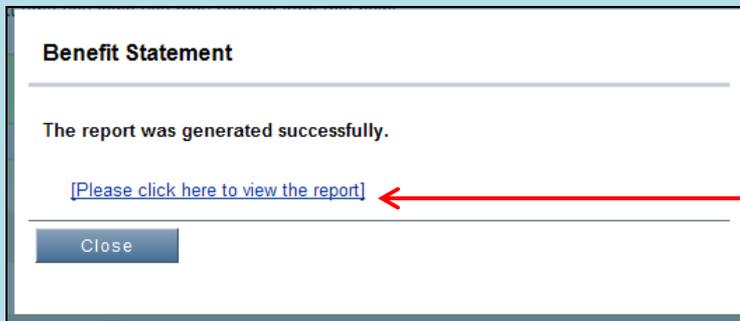
Select "Benefit Statement" under the "Tools" menu.



Click "Generate" to create your report. It will only show your current in force coverage, not your unapproved requests.

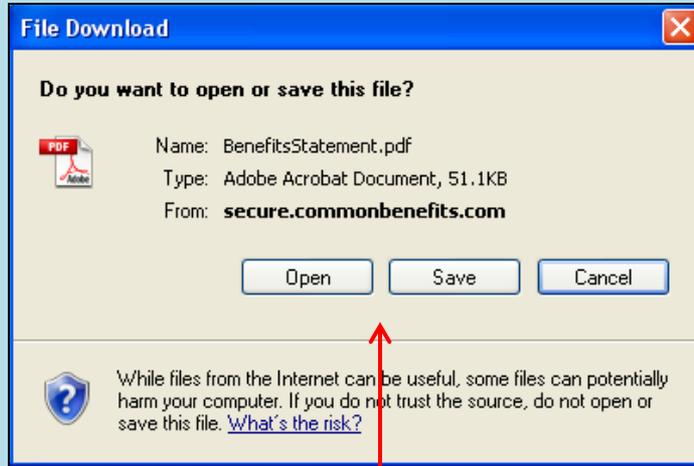


Please wait while your statement is being created. It may take a few moments.



You will be notified when the statement is completed. Click the link to view the report.

Your Benefit Statement



The file will download to your computer. You will be able to open a PDF summarizing your currently enrolled benefits. You may print this report to have on record. Note: it will not reflect your requested changes until they are processed by an administrator.

