

Step 1: Visit: [Login | BenSel](#)



Enter EEID and PIN

PIN = Last 4 of your EEID + full birth year

Example: EEID 456789

Birth Year: 1958



PIN = 67891958





Welcome

To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN). If you have questions or need help, please contact your Human Resources Department.


Administrative users: login to the [ADMINISTRATIVE SITE](#).

 Employee Number 

 PIN 

[FORGOT PIN?](#) [Log in](#)

By providing your user name and password, you are agreeing to the [Terms of Use Agreement](#)



Step 2: You will see the 'Welcome Screen' - Click 'Next'

Welcome LTCS Test Test,

Kaweah Health Care District is excited to announce our new employee benefit, Allstate Group Whole Life Plan with Accelerated Death Benefit for Long Term Care (LTC)! This benefit is designed to help you and your family plan for the high cost of Long Term Care by combining the benefits of Life Insurance with Long Term Care which can be used during your living years.

✓ Your Benefit Options

[GWL with LTC](#)



Enrolling for additional coverage is easy as 1,2,3!

- 1. Review personal information
- 2. Provide your tobacco status and choose your additional benefit
- 3. Sign and submit enrollment form

Click *Next* to begin.

Press *Next* to review personal information and begin enrollment.

Next >

Step 3: Confirm Personal Information is Correct

Personal Info

Please fill out the following information completely. All of this information is required to complete your benefit enrollment. If you have questions, please contact your Human Resources representative.

SSN:

First Name Middle Initial Last Name

Date of Birth:

Gender: ☐ Male ☐ Female ☐ Other

Contact Info

Please enter your complete contact information. Press Submit when you are ready to log onto the enrollment system. Be sure and keep your PIN in a safe place. This is your "secret code" for accessing the system, and is the equivalent of your digital signature.

Address: USA
Country

Street Address Line 1

Street Address Line 2

Step 4: Add your Spouse/Dependent – Click 'Next'

Home You & Your Family My Benefits Sign & Submit

Back Next

Dependents

Click Add ("Plus" icon at top right of table) to add your spouse or dependent children. Dependent children may only be covered in a plan if they meet the necessary requirements defined by the plan. Click the Next button when you are finished.

Dependents

No Dependent Information Available

Name	SSN	DOB	Sex	Relation	Uploads	+
No items found.						

Add a Dependent

If your dependent is not listed above or you would like to add an additional dependent, simply click the Add Dependent button below.

[+ Add Dependent](#)

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Step 5: Confirm Tobacco Status

Advantages of the Allstate Group Life Plan with Accelerated Death Benefit for Long Term Care (LTC)

1

Three Ways to Receive Benefits
Life Insurance
LTC Insurance
Life & LTC Insurance

2

Issue Age Rate
Rates are based on your age when policy is issued.
Rates do not increase as you age.

3

Wherever You Go, Take it with You
If you leave employment, your coverage is portable at the same rate.

My benefits

Cost with LTC

\$0.00

Total Cost for group

\$0.00

Pre-Existing Condition

Pre-Existing Conditions

We will not pay benefits under this policy for a period of one hundred and ninety (190) days after the date of diagnosis of a pre-existing condition, unless the condition was not known to exist at the time the policy was issued. For purposes of this section, a condition is a disease, illness, injury, or other medical condition that exists at the time the policy was issued, or that is discovered within a specified period of time after the policy is issued, and that is a condition that is not covered by the policy.

For purposes of this section, a condition is a disease, illness, injury, or other medical condition that exists at the time the policy was issued, or that is discovered within a specified period of time after the policy is issued, and that is a condition that is not covered by the policy.

Annual Premium (Death Benefit)	Maximum Monthly LTC Benefit	Maximum Total LTC Benefit Available
\$10,000	\$400	\$4,800
\$15,000	\$600	\$7,200
\$20,000	\$800	\$9,600
\$25,000	\$1,000	\$12,000
\$30,000	\$1,200	\$14,400
\$35,000	\$1,400	\$16,800
\$40,000	\$1,600	\$19,200
\$45,000	\$1,800	\$21,600
\$50,000	\$2,000	\$24,000
\$55,000	\$2,200	\$26,400
\$60,000	\$2,400	\$28,800
\$65,000	\$2,600	\$31,200
\$70,000	\$2,800	\$33,600
\$75,000	\$3,000	\$36,000
\$80,000	\$3,200	\$38,400
\$85,000	\$3,400	\$40,800
\$90,000	\$3,600	\$43,200
\$95,000	\$3,800	\$45,600
\$100,000	\$4,000	\$48,000

Please see below for additional benefits included in optional riders you may add.

Benefits paid under the Long-Term Care and other Accelerated Death Benefit riders may, however, be subject to the death benefit and other terms of the life insurance coverage. The beneficiary should not receive the death benefit until 180 days after the Accelerated Death Benefit for Long-Term Care rider.

Insurance for LTC Test Test

Has the employee used tobacco in the last 12 months?

Is there any other individual life insurance in force or applied for on the proposed insured?

Step 6: Review Plan/Rates and select coverage amount

Monthly Cost	Benefit Amount
<input type="radio"/> \$5.67	10,000
<input type="radio"/> \$11.35	20,000
<input type="radio"/> \$17.02	30,000
<input checked="" type="radio"/> \$22.70	40,000
<input type="radio"/> \$28.37	50,000
<input type="radio"/> \$34.05	60,000
<input type="radio"/> \$39.72	70,000
<input type="radio"/> \$45.40	80,000
<input type="radio"/> \$51.07	90,000
<input type="radio"/> \$56.75	100,000

Application riders

☒ Accelerated Death Benefit for Terminal Illness or Condition

☒ Accelerated Death Benefit for Long Term Care

Total Premium: \$22.70

☒ I wish to apply for this coverage

☐ I wish to DECLINE this coverage

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Step 7: Choose Beneficiaries

Choose Beneficiaries

A beneficiary is a person, trust, or organization to whom benefits will be paid. A contingent beneficiary will receive benefits if your primary beneficiary is no longer living at the time of your death.

- Place a checkmark next to each desired primary and contingent beneficiary. The percentage allocations will automatically calculate.
- Click Add if you do not see the desired person or trust in the list.
- You may change the percentages, as long as they add up to 100%.
- Clicking All living children will clear any children already selected.
- Beneficiaries may not be both primary and contingent at the same time.

Beneficiary	Relationship	Primary	Contingent	
All Living Children		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	/ ✕
Estate		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	/ ✕

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Step 8: Submit spouse application or click “Next” if not applying for spouse coverage.

GWL with LTC

Each person currently covered is listed below. If you wish to make a change to the coverage, click the person's name.

Primary Insured	Relationship	DOB	Policy #	Benefit	Premium	Options	
LTC	Employee	2/1/1974		250,000	\$635.82	GWCTI, GWCLTCRE	Withdraw

You can apply for coverage for any of the individuals listed below. To view prices or apply, click the name of the person in the list below.

Name	Relationship	Sex	DOB	Riders
Spouse Test Test	Spouse	M	3/1/1970	

- ☒ I wish to CONFIRM the changes made in this enrollment session.
- ☐ I wish to WAIVE coverage (no previous election made), or I wish to CANCEL changes (to a previous election made)

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Step 9: If applying for spouse - answer Spouse Tobacco/Eligibility questions

Insurance for Test Spouse

Has the employee's spouse used tobacco in the last 12 months?

No

Is the employee's spouse actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?

Yes

Step 10: Select coverage amount and choose “Next”

<input type="radio"/> \$135.49	40,000
<input checked="" type="radio"/> \$169.37	50,000
<input type="radio"/> \$254.06	75,000
<input type="radio"/> \$338.74	100,000
<input type="radio"/> \$423.43	125,000
<input type="radio"/> \$508.12	150,000

Base Policy

\$169.37

Application riders

☒ Accelerated Death Benefit for Terminal Illness or Condition

☒ Accelerated Death Benefit for Long Term Care with Restoration and Extension of Benefits

6%

Total Premium: \$

☒ I wish to apply for this coverage

☐ I wish to DECLINE this coverage

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Step 11: If applying for spouse - choose beneficiaries for spouse policy

- Choose Beneficiaries
- A beneficiary is a person, estate, trust, or organization to whom benefits will be paid in the event of the primary insured's death. Proceeds due shall be paid in a lump sum to the Primary Beneficiaries, if any are living; otherwise to the Contingent Beneficiaries, if any are living; otherwise as provided in the policy/certificate.
- Place a checkmark next to each desired primary and contingent beneficiary. The percentage allocations will automatically calculate.
 - Click Add if you do not see the desired person or trust in the list.
 - You may change the percentages, as long as they add up to 100%.
 - Clicking *All living children* will clear any children already selected.
 - Beneficiaries may not be both primary and contingent at the same time.

Beneficiary	Relationship	Primary	Contingent	
LTCS Test Test	Employee	<input checked="" type="checkbox"/> 100%	<input type="checkbox"/> 0%	<div></div>
All Living Children		<input type="checkbox"/> 0%	<input type="checkbox"/> 0%	<div></div>

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Step 12: Confirm selections or change by clicking on the applicants name

GWL with LTC

Each person currently covered is listed below. If you wish to make a change to the coverage, click the person's name.

Primary Insured	Relationship	DOB	Policy #	Benefit	Premium	Options	
LTCS Test Test	Employee	2/1/1974		250,000	\$635.82	GWCTI, GWCLTCRE	<div>Withdraw</div>
Spouse Test Test	Spouse	3/1/1970		50,000	\$169.37	GWCTI, GWCLTCRE	<div>Withdraw</div>

☒ I wish to CONFIRM the changes made in this enrollment session.

☐ I wish to WAIVE coverage (no previous election made), or I wish to CANCEL changes (to a previous election made)

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Step 13: Read statement and click “Next”

Protection Against Unintended Lapse: *I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of my coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.*

I understand that I have the right to designate, change or revoke an additional addressee at any time, with timely notice to the Company.

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Step 14: Elect an additional addressee to receive unintentional lapse notice

Designate an additional addressee to receive such notice.


☒ I elect to

☐ I elect not to

Full Name	Address	City	State	Zip	Phone	+

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Step 15: Answer Questionnaire

Accelerated Death Benefit for Long Term Care

Is this rider to replace or change any existing long term care coverage or life insurance coverage including accelerated death benefits?

LTCS Test Test

☐ Yes ☒ No

Spouse Test Test

☐ Yes ☒ No

Is there any other long term care insurance in force (including health care service contract or health maintenance organization contract) on the proposed insured?

LTCS Test Test

☐ Yes ☒ No

Spouse Test Test

☐ Yes ☒ No

Has there been any other long term care insurance in force during the last 12 months on the proposed insured?

LTCS Test Test

☐ Yes ☒ No

Spouse Test Test

☐ Yes ☒ No

Step 16: Document List

Accelerated Death Benefit for Long Term Care Rider Checklist. You will receive the following documents as part of this enrollment:

- Accelerated Death Benefit for Long Term Care Rider Outline of Coverage
- Accelerated Death Benefit for Long Term Care Rider Summary and Disclosure Statement
- Summary of Accelerated Death Benefit for Long Term Care Rider
- Important Notice to Applicant
- Notice to Applicant Regarding Replacement of Long-Term Care Insurance or Life Insurance Including Accelerated Death Benefits

This contract for long term care rider is not intended to be a federally qualified long term care insurance contract.



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Step 17: Answer underwriting questions if applying above Guarantee Issue limits

Underwriting Questions

To the best of your knowledge, in the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for Acquired Immune Deficiency Syndrome (AIDS)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.**

☐ Yes ☐ No

To the best of your knowledge, in the last 6 months, has the person(s) to be insured been disabled or hospitalized for anything other than lacerations or broken bones due to an accident, or normal pregnancy?

☐ Yes ☐ No

To the best of your knowledge, in the last 2 years, has a member of the medical profession diagnosed, treated, or counseled the person(s) to be insured for any of the following?

☐ Yes ☐ No

- | | |
|---|---|
| • Anemia (other than iron deficiency) | • Kidney Disease/Disorder (including dialysis and/or chronic renal failure) |
| • Anxiety, depression or other mental or nervous illness (that resulted in hospitalizations, disability from work, or suicide attempts) | • Liver Disease/Disorder (including but not limited to hepatitis, fatty liver, cirrhosis, primary sclerosing, colangitis, or hemachromatosis) |
| • Asthma (only if taking steroidal medication and/or have been hospitalized) | • Lou Gehrig's Disease (ALS) |
| • Cancer, except basal cell carcinoma | • Lung Disease/Disorder (other than asthma, including but not limited to chronic |
| • Diabetes | |

Step 18: Authorization – if applying above GI limits

REPRESENTATION. I have read or had read to me this completed form. I represent that statements and answers given on this form are representations, not warranties, and are true, complete, and correctly recorded to the best of my knowledge and belief.

☒ I Agree

AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE). I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company or MIB, Inc. that has records or knowledge of my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any medical information for the purpose of underwriting of insurance for which I am applying. **This authorization excludes disclosure of the result of a test for HIV if I have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in the caveat will prohibit this authorization from including the fact that I have been diagnosed with or treated for AIDS.** I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any minor dependent for whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

EMPLOYEE EMPLOYMENT STATUS. I certify that I work now, for wage or profit, and I have worked at least 20 hours each week performing all duties of my regular occupation at my regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

Fraud Warning Notice: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Caution: If your answers on this application are misstated or untrue, AHL may have the right to deny benefits or rescind your Accelerated Death Benefit coverage, if applied for.



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Step 19: Review your Benefits Section – To make changes, click Back. Click ‘Confirm’ when finished.

Enrollment Details

Person Name	Relationship	Description	Policy #	Cost
TEST TEST	Employee	AB Group Whole Life (GWL); ED		\$65.85

Beneficiary Information

Name	Relationship	Address	Phone	Percent	Type
All Living Children				100.00	Primary

Monthly deduction

Cost: \$65.85 (post-tax)

You have elected coverage under this plan. Please review the summary information above and press Confirm if it is correct. To make changes, press Back.

[Back](#) [Confirm](#)

My Benefits

GWL with LTC	\$0.00
Total Cost Per Month	\$0.00


Step 20: Enter your Bank Account Information

Payment Information

You may pay by automatic withdrawal from a checking or savings account. Premiums will be deducted from the bank account you choose each month. Please select the desired method of payment.

Payment Type:

Your monthly premium will be withdrawn directly from your checking or savings account on the specified day of each month. If you are using a checking account, you will find the account number at the bottom of your check, next to the routing number (see illustration). Click **Next** when you are ready.



① 00005518946
Transfer/ABA Number
② 123456789
Account Number
③ FIRST NATIONAL BANK
331 Main St
Boulder, CO 80502-8271
Institution Name/Address

Type of Account:

Account No.:

Transfer/ABA No.:

Account Holder Name:

Bank Draft Day:

Depository Name/Branch:

Address:

City:

State:

ZIP:

[Back](#) [Next](#)

Next will skip the step of entering payment information and you will not be able to complete your enrollment.

Step 21: Review your Enrollment Forms

Sign and Submit

Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your contributions **per Month** for each plan.

- **Are You Satisfied With Your Elections?** If you are satisfied with your choices, click on the **"NEXT"** button at the bottom of this screen to sign your Enrollment Verification Form electronically using your PIN.
- **Need to Make Some Changes?** If you wish to make any changes to your elections, click on the benefit plan name in the menu on the left.

Your Benefits

Plan	Description	Pretax Cost	Posttax Cost
GWL with LTC	AB Group Whole Life (GWL); EO	\$0.00	\$65.85
Total		\$0.00	\$65.85

Signatures Required

To complete your enrollment, you must sign the following forms. Press **Next** to begin signing forms.

Form Name	Status	Date Signed/Reviewed
<input type="checkbox"/> ABJOGWLTCLWA Outline of Coverage	Not Reviewed	N/A
<input type="checkbox"/> ABJ21526WA SUMMARY AND DISCLOSURE STATEMENT	Unsigned	
<input type="checkbox"/> ACH Authorization	Unsigned	
<input type="checkbox"/> ACH Confirmation	Unsigned	

[Next](#)

Step 22: Place a check mark next to the forms to sign


Review / Sign Forms

Your enrollment will not be complete until you review and sign the forms listed below. By entering your electronic signature below, you are giving your consent to the electronic signature (e-signature) process and authorization to use electronic records and electronic signatures connected with your enrollment. If you decline the e-signature process, you will not be able to complete your enrollment electronically.

Please review each document carefully and place a checkmark next to each before signing.

Form Name
<input checked="" type="checkbox"/> ABJ13510 SUMMARY AND DISCLOSURE STATEMENT
<input checked="" type="checkbox"/> AWD13513WA SUMMARY AND DISCLOSURE STATEMENT
<input checked="" type="checkbox"/> ABJ06ULTC2WA Outline of Coverage

Employee: By clicking the Sign Form button, I am electronically signing the form listed above.

 [Sign Form](#)

[Next](#)

Step 23: Click 'Sign Form' – Enter PIN to Sign

Enrollment Agreement / Deduction Authorization

- To the best of my knowledge and belief, all statements and answers made on this form and all associated application forms are true, complete, and correct.
- I understand that omissions or misrepresentations in the information I have provided may constitute fraud and may result in my coverage being void.
- If I elect an amount over guaranteed issue maximum, I understand that subject to underwriting review, my coverage may be reduced to the guaranteed issue maximum, if applicable. If my benefit amount is reduced, I understand recurring withdrawals will be reduced accordingly, but will never be more than what I authorize above.
- Upon acceptance by the insurers, I hereby authorize the Carrier to deduct from my Bank Account the amounts indicated above.
- My authorization shall continue thereafter until written notice from me cancelling this authorization.

Your total monthly deductions...

Total Deductions
\$ 65.85

Employee Signature _____ Date _____

[Download](#)

Please enter your PIN/Password below and click on **"SIGN FORM"** to complete your enrollment and submit your elections. By entering your PIN/Password, you are electronically signing the **Benefit Verification/Deduction Confirmation Form** above. Please review it carefully before entering your PIN/Password.

 PIN: [Sign Form](#)

Sign/Submit Complete





Recap of Your Elections

Enrollment Details

Person Name	Relationship	Description	Policy #	Cost
TEST TEST	Employee	AB Group Whole Life (GWL); ED		\$65,825

Name	Relationship	Address	Phone	Percent	Type
All Living Children				100.00	Primary

Press Logout to exit the website.

Form Name	Date Signed/Reviewed
 ABJ02WLTCHWR Outline of Coverage	N/A
 ABJ0152088A SUMMARY AND DISCLOSURE STATEMENT	09/02/2021
 ACH Authorization	09/02/2021
 ACH Confirmation	09/02/2021

Step 25: Print ACH Confirmation for your Record

Benefit Verification / ACH Confirmation			
Name TEST TEST	SSN 1454545454	Employee ID 00000001	Reason for Completing Form Open Enrollment
Location Headquarters	Department default	Job Class Full Time	
Work Phone	Home Phone	E-mail	Address 14715 NE 55th Street Suite 200 Redmond WA 98052
Benefit Deduction Summary			
Plan	Product	Cvg	Cost
GWL with L/C	AB Group Whole Life (GWL)	EO	\$5.85
			Total \$5.85
Enrollment Agreement / Deduction Authorization			
<p>I, the undersigned, hereby authorize the Company to deduct from my pay the amount indicated above for the purpose stated.</p> <p>I understand that if I fail to provide adequate funds for deduction, my coverage may be reduced or terminated.</p> <p>If I select an amount over guaranteed issue maximum, I understand that subject to underwriting review, my coverage may be reduced or terminated. If my benefit amount is reduced, I understand recurring withdrawals will be reduced accordingly, but will never be more than what I authorize above.</p> <p>Upon acceptance by the insurer, I hereby authorize the Carrier to debit from my Bank Account the amounts indicated above.</p> <p>My authorization shall continue thereafter until written notice from me cancelling the authorization.</p>			
Your total monthly deductions:	Total Deductions \$ 65.85	[*****] Electronic Signature on File Employee Signature	09/02/2021 Date