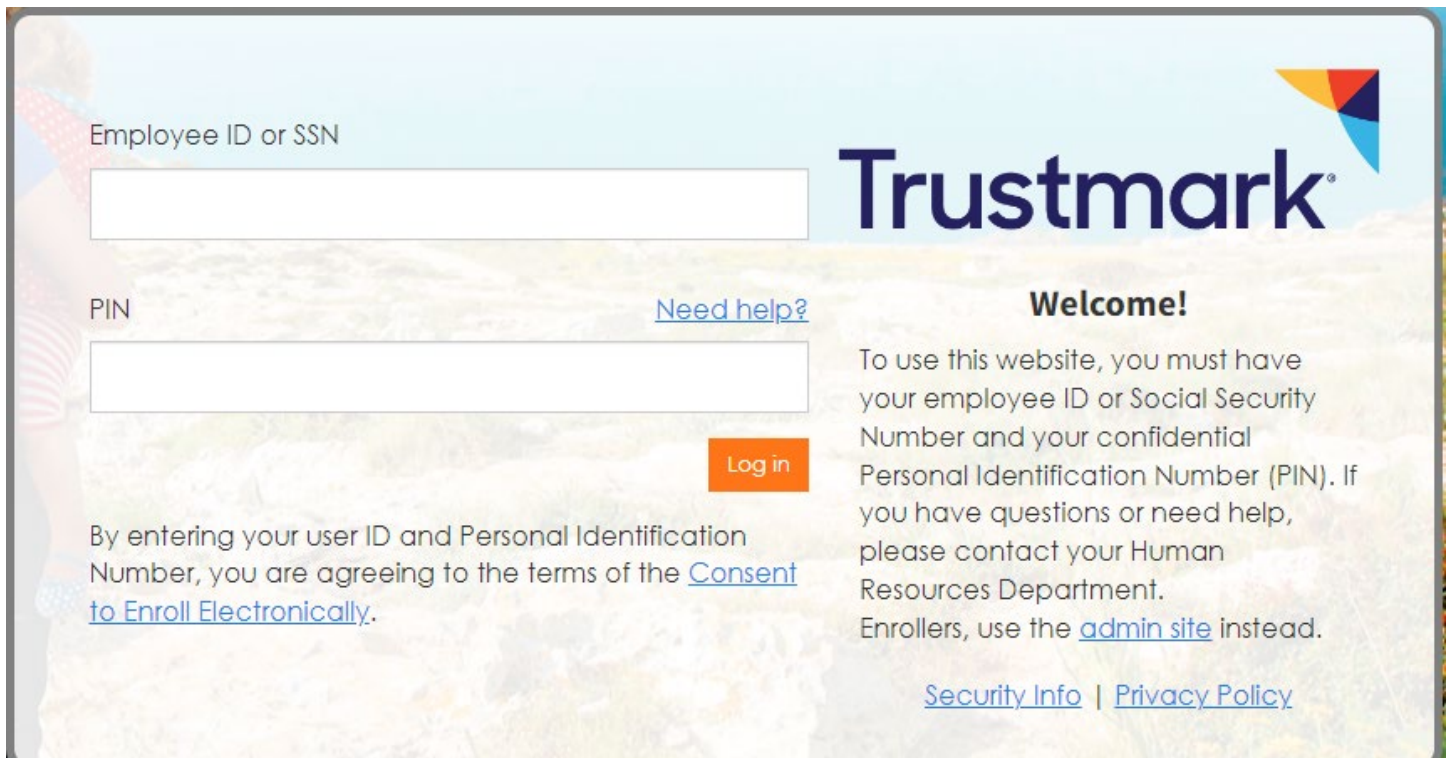


Trustmark Selerix Self-Enrollment Guide for City of Lee's Summit 2025

1. Go to www.cityoflsbenefits.com. Hover over the "Enrollment" tab, then choose "Open Enrollment" from the dropdown. Then click on "Enroll in 2025 Benefits."
 - a. Enter your Employee ID or full SSN (no dashes).
 - b. PIN = Password and that will be the last four of your SSN + the last 2-digits of your birth year (EX: SSN with last four of 1234 and birth year of 1972 would result in a PIN of 123472)
 - c. If you have any issues or questions about the process, you may feel free to call the Enrollment Center at 1-844-350-4040.
 - Call Center Hours: 8:30 am–5:00 pm Monday-Friday, October 21 – November 8.
 - The Call Center will also be open until 6:00 pm on Tuesdays and Thursdays during the open enrollment period.
 - d. If you get interrupted in the middle of your enrollment process, your work to that point will be saved. Just log in again later and pick up where you left off.




The screenshot shows the Trustmark Selerix Self-Enrollment website. On the left, there are two input fields: "Employee ID or SSN" and "PIN". Below the "PIN" field is an orange "Log in" button. To the right of the "PIN" field is a blue link "Need help?". Below the "Log in" button is a paragraph of text: "By entering your user ID and Personal Identification Number, you are agreeing to the terms of the [Consent to Enroll Electronically](#)." On the right side of the page, there is a "Welcome!" heading followed by a paragraph: "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. Enrollers, use the [admin site](#) instead." At the bottom right, there are two blue links: "Security Info" and "Privacy Policy". The Trustmark logo is in the top right corner. The background of the page is a light blue and white pattern.

2. You should now be at the “Welcome” screen. Here you will click on “Next” in the upper right or bottom right corner to review your personal info, review your dependents, add dependents if needed, and begin your enrollment.

Home You & Your Family My Benefits Sign & Submit [Next >](#)

Welcome to Your Benefits Enrollment for Plan Year 2025



✓ Your Benefit Options

- [Health](#)
- [Health Savings Account](#)
- [Critical Illness](#)
- [Accident Coverage](#)
- [Health Care FSA](#)
- [Dependent Care FSA](#)
- [Limited FSA](#)
- [Dental](#)
- [Vision](#)
- [Basic Life](#)
- [Basic AD&D](#)
- [Dependent Group Life](#)
- [Trustmark Universal Life](#)
- [Employee Voluntary Term Life](#)
- [Spouse Voluntary Term Life](#)
- [Child Voluntary Term Life](#)
- [Employee AD&D/Employee + Family AD&D](#)
- [Short-term Disability](#)
- [Long-term Disability](#)
- [EAP](#)



You will need the following to complete the enrollment process:



15-20 minutes



Information about your spouse/dependent(s)



Keep your financial needs in mind as you review benefits

Benefits selection and enrollment is easy!



1 Review family information



2 Choose your benefits



3 Sign and submit

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

[Next >](#)

- If all your personal info is correct, click "Next" in the upper or lower right-hand corners of the screen. Please note that optional fields are in italics while required fields are in a regular font.
****Please note that you are unable to make changes to your name on this page. If you have a name change, please contact Christina Garside at 816-969-1042.**

Personal Information

i Please review your personal information to ensure it is correct and complete. Please correct any errors and click the *Next* button when you are finished.

Optional items are in *italics*.

Please contact HR if corrections are needed for Date of Birth, Gender, or Social Security Number values.

Personal Info

Name :
First *MI* Last *Suffix*

Date of Birth: 01/21/1988

SSN: ***-**-3434

Gender Assigned At Birth : Male Female Other

Contact Info

Address:
Country

Street

Street (cont.)

City

State

Zip

Home Phone:

Work Phone:

Mobile Phone:

E-MAIL:

Why are we asking for your email address?
PERSONAL EMAIL:

[← Back](#)

[Next →](#)

4. On the Dependents screen you will want to verify that the dependents you wish to cover for any coverages are listed. If you need to add a dependent, you will need to have the dependent's DOB and SSN.

To add a dependent click the "+" sign on the right side of the page in the blue bar or click the blue "Add Dependent" button. If a dependent has already been added and you need to edit their information, select the pencil icon. Once completed click Next.

Home You & Your Family My Benefits Sign & Submit Back Next






Dependents

i On this screen, please add and/or review information about your dependents.

- This is important to do now so that you can **enroll them in any eligible coverage**. It will also let you **designate them as beneficiaries**, if applicable.
- Click the **"plus" button** at the top right of the table, or the blue **"Add Dependent" button** below the table, to add a new dependent. You can also **click a name in the table** to review and edit information.

When all your dependent information is correct, **click the "Next" button** to the bottom right.

Dependents

Name	SSN	DOB	Sex	Relation	Uploads	
Susie Test	***-**-4490	2/2/1968	F	Spouse	0	  
John TEST	***-**-2223	2/4/2005	M	Child	0	 

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 Back Next

5. Input dependent information and click “Save” when complete. Once you are finished adding any dependent information it will take you back to the Dependent page and you will click Next.

Dependent Info

Relationship:

Name:
First MI Last Suffix

Date of Birth:

SSN:

Gender: Male Female Other

Full-time Student: Yes No

Disabled: Yes No

Address: Same as employee


Country

Street

Street (cont.)

City State Zip

Email Address:




6. On the Health page you will answer the question regarding whether your spouse is also an employee of the City of Lee’s Summit and click Next.

Health

Is your spouse an employee of City of Lee's Summit?

Yes
 No

Please indicate which applies to your spouse.



7. As this is an active enrollment you will be taken through all the benefits screens starting with **Health** for you to review/change your elections if you choose. Once you have made any necessary changes or if you are good to continue with your current coverage, click Next at either the top or bottom of the screen.

Home You & Your Family My Benefits Sign & Submit Back Next

Health

Medical Plan

City of Lee’s Summit’s medical options all provide coverage for the same types of expenses, such as doctor’s office visits, preventive care, prescription drugs and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage. The City’s Medical Plan is administered by Cigna.

Choosing a Medical Option

When it comes to medical coverage, the City of Lee’s Summit offers you these choices:

- Cigna Buy Up PPO Plan (\$0 deductible)
- Cigna Base PPO Plan (\$500 deductible)
- Cigna HDHP with HSA Plan (\$3,300 deductible)

[Click here for more information about your benefits www.cityoflsbenefits.com.](http://www.cityoflsbenefits.com)

■ Listed below are the options and coverage choices available to you.

- To enroll or continue your current coverage, click the option that represents your election.
- On the next screen, you can edit which dependents to cover.
- Click **Next** to continue.

▶ View Existing Coverage

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
CIGNA - Buy Up PPO Plan (\$0 Deductible)	<input type="radio"/> \$95.74	<input type="radio"/> \$359.36	<input type="radio"/> \$359.36	<input type="radio"/> \$416.99
CIGNA - Base PPO Plan (\$500 Deductible)	<input type="radio"/> \$47.24	<input type="radio"/> \$259.98	<input type="radio"/> \$259.98	<input type="radio"/> \$301.80
CIGNA - HDHP with HSA Plan	<input type="radio"/> \$0.00	<input type="radio"/> \$136.13	<input type="radio"/> \$136.13	<input checked="" type="radio"/> \$157.99
Waive Health	<input type="radio"/> \$0.00			

Back

Next

- The next screen is going to verify who will be covered for your health benefit and you can make changes by selecting the check box next to the name of the dependent. Once complete, click Next at either the top or bottom of the screen.

Home You & Your Family ▾ My Benefits ▾ Sign & Submit

◀ Back Next ▶

Health

Application Details

Individuals to Be Covered
Click on the checkbox next to each person's name to be included for coverage. When you are finished, click on the "NEXT" button to continue.

Plan Name: Health
Coverage Level: Employee + Family

To Be Covered?	Name	Age
<input type="checkbox"/>	Test Jones	58
<input checked="" type="checkbox"/>	Spouse Jones	58
<input type="checkbox"/> Age 28 exceeds maximum age.	Daughter Jones	28
<input checked="" type="checkbox"/>	Son Jones	23

◀ Back Next ▶

- If you choose the HDHP health plan you are entitled to enroll in a Health Savings Account (HSA). You can enter in the amount you wish to contribute per paycheck and the calculator will show you the total amount of your contribution. If you go over the Maximum Allowable Contribution amount the system will automatically default to the max amount you can contribute. Once complete, click Next at the bottom of the screen.

Health Savings Account

City of Lee's Summit Contributions

If you elect HDHP coverage, when you set up an HSA, City of Lee's Summit will contribute \$50 per month to the account for you. If you enroll in the HDHP mid-year, the amount City of Lee's Summit contributes will be pro-rated.

Here's a look at what you and City of Lee's Summit together can contribute to your HSA each year:

Coverage Level	2025 Maximum HSA Contribution
Individual	\$4,300
Family	\$8,550
Age 55 & Older	An additional \$1,000

[Click here for more information about your benefits www.cityoflsbenefits.com.](http://www.cityoflsbenefits.com)

Your HSA Election

A health savings account allows you to set aside pre-tax money to pay for expenses not covered by your insurance. The maximum contribution amounts for the next plan year are shown below.

- If you would like to enroll in the HSA plan, enter the amount you would like to contribute for plan year. Then click on the button next to the text which reads "I wish to apply for this coverage".
- If you do not want to enroll in the HSA, click on the button next to the text which reads "I wish to DECLINE this coverage".
- When you are finished, click "NEXT" to continue.

▶ View Existing Coverage

Minimum Annual Contribution:	\$600.08
Maximum Annual Contribution:	\$9,550.00
Employer Per Pay Period Contribution:	\$23.08
Amount per pay period:	<input type="text" value="\$100.00"/>
Number of periods:	26
Total Amount:	<input type="text" value="\$3,200.08"/>

Calculate

← Back

Next →


10. In addition, on the right-hand side of the screen, you will see a box entitled *My Benefits*. When you have completed the enrollment for a benefit it will be marked with a green checkmark. Benefits that have a red x are unable to be modified. Any benefit with an empty circle still needs attention. You will also be able to monitor the total payroll costs as you are completing your enrollment process.


My Benefits	
<input checked="" type="checkbox"/> Health	\$2.89
<input checked="" type="checkbox"/> Health Savings Account	\$150.00
<input checked="" type="checkbox"/> Critical Illness	\$15.92
<input type="checkbox"/> Accident Coverage	\$0.00
<input checked="" type="checkbox"/> Health Care FSA	\$0.00
<input type="checkbox"/> Dependent Care FSA	\$0.00
<input type="checkbox"/> Limited FSA	\$0.00
<input checked="" type="checkbox"/> Dental	\$0.00
<input checked="" type="checkbox"/> Vision	\$0.00
<input checked="" type="checkbox"/> Basic Life	\$0.00
<input checked="" type="checkbox"/> Basic AD&D	\$0.00
<input checked="" type="checkbox"/> Dependent Group Life	\$0.00
<input type="checkbox"/> Trustmark Universal Life	\$0.00
<input type="checkbox"/> Employee Voluntary Term Life	\$0.00
<input checked="" type="checkbox"/> Spouse Voluntary Term Life	\$0.00
<input checked="" type="checkbox"/> Child Voluntary Term Life	\$0.00
<input checked="" type="checkbox"/> Employee AD&D/Employee + Family AD&D	\$4.15
<input checked="" type="checkbox"/> Short-term Disability	\$0.00
<input checked="" type="checkbox"/> Long-term Disability	\$0.00
<input checked="" type="checkbox"/> EAP	\$0.00
Employer Cost	\$426.96
Pre-tax cost	\$152.89
Post-tax cost	\$20.07
Total Cost Total Per Pay Period	\$172⁹⁶


11. In each benefit section, you will have the option to enroll in your preferred plan and select your coverage tier or decline the coverage. Once complete, click *Next* at the bottom of the screen.

Critical Illness

Need Help? Call 1-855-396-7655 (855-EZ-NROLL)

Why Critical Illness?


Learn More


Customer Reviews

See what others are saying about The Hartford

With Critical Illness insurance, you'll receive a lump-sum payment when a covered illness is diagnosed. You can use the payment in any way you choose, including expenses not covered by your medical insurance and day-to-day living expenses (i.e. rent or mortgage payments, groceries, child care, utility bills, etc.).

Why It's Important

A major illness – such as cancer, a heart attack or stroke – can leave you emotionally, physically and financially overwhelmed. Critical Illness insurance can help relieve the financial impact of an illness so you can focus on recovery.

Your Employer's Plan Details

A claim for benefits may not be approved for a pre-existing condition, as stated in the applicable policy.

Listed below are the options and coverage choices available to you.

- To enroll or make changes, click on the button next to the cost which represents your election.
- When you are finished, click on the "NEXT" button to continue.
- Rates and/or benefits may be changed on a class basis.

[Click here for more information about your benefits www.cityoflsbenefits.com.](http://www.cityoflsbenefits.com)

Please select the desired benefit level

Benefit Levels: Non-Smoking Smoking

Employee Only	Employee + Spouse	Employee + Children	Employee + Family
<input type="radio"/> \$11.26	<input type="radio"/> \$17.55	<input type="radio"/> \$12.20	<input checked="" type="radio"/> \$18.65

Benefit Amount:  \$10,000

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

THIS POLICY PROVIDES LIMITED BENEFITS FOR SPECIFIED DISEASES ONLY. This limited health benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Critical Illness Form Series includes GBD-2600, GBD-2700, or state equivalent.

* Information regarding dependent benefit amounts (if applicable) is available through the "Your Employer's Plan Details" link, above.

- I wish to apply for this coverage
- I wish to DECLINE this coverage

To **add** the coverage select **I wish to apply for this coverage.**

To **decline** coverage select **I wish to DECLINE this coverage**

[← Back](#)

[Next →](#)

12. If on any of the plans you are trying to choose a tier for which you don't have dependents entered, you will see a yield sign indicating you need to first add your dependents before you can enroll.

CIGNA DENTAL

Your Cost: Per Pay Period

Employee Only: \$0.00

Employee+Family: \$19.53

Covered People: ✎

Test Test

⚠

[Enroll](#)

Choose the "You & Your Family" drop down menu at the top of the screen then choose "Spouse & Dependents" to go back and add additional family members.

LS LEE'S SUMMIT MISSOURI Status (61% Complete)

Home You & Your Family My Benefits Sign & Submit

Home You & Your Family My Benefits Sign & Submit Back Next

Dependents

i On this screen, please add and/or review information about your dependents.

- This is important to do now so that you can **enroll them in any eligible coverage**. It will also let you **designate them as beneficiaries**, if applicable.
- Click the **"plus"** button at the top right of the table, or the blue **"Add Dependent"** button below the table, to add a new dependent. You can also **click a name in the table** to review and edit information.

When all your dependent information is correct, **click the "Next" button** to the bottom right.

Dependents

Name	SSN	DOB	Sex	Relation	Uploads	+
Susie Test	***-**-4490	2/2/1968	F	Spouse	0	✎ ✕
John TEST	***-**-2223	2/4/2005	M	Child	0	✎ ✕

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

< Back

Next >

13. For the Trustmark Universal Life coverage, the Quick Enroll button can be used to waive this benefit. The Quick Enroll button will be shown when viewing from the Benefit Summary. Or, if you are at this screen and wish to waive this benefit, choose “I wish to CANCEL changes made in this enrollment session” and click “Next.”



You may 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
Hartford Test	Employee	M	10/14/1980	
Test Hartford	Spouse	F	10/14/1982	
Tester Hartford	Child	F	10/14/2018	

I do wish to CONFIRM changes
 I wish to CANCEL changes made in this enrollment session.

Back

Next

a. When reviewing the Trustmark Universal Life benefit to determine whether to elect coverage or to make a change in your current coverage, click on the name of the individual you want to review.



You may 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
Hartford Test	Employee	M	10/14/1980	
Test Hartford	Spouse	F	10/14/1982	
Tester Hartford	Child	F	10/14/2018	

I do wish to CONFIRM changes
 I wish to CANCEL changes made in this enrollment session.

Back

Next

- b. Select the appropriate smoker/non-smoker status from the drop down to ensure the accuracy of the rates displayed.
- c. Then, click the radio button that corresponds to the benefit level of your choosing. If you prefer an amount not listed, you can input a custom amount based on cost per pay period or benefit amount by entering these values below and clicking the calculator icon.

Insurance for Hartford Test

Does anyone proposed for coverage smoke cigarettes or during the past 12 months has anyone proposed for coverage smoked cigarettes? No

Cost per Pay Period	Benefit Amount
<input checked="" type="radio"/> \$6.00	<u>12,590</u>
<input type="radio"/> \$10.27	<u>25,000</u>
<input type="radio"/> \$18.88	<u>50,000</u>
<input type="radio"/> \$27.48	<u>75,000</u>
<input type="radio"/> \$36.09	<u>100,000</u>
<input type="radio"/> \$53.30	<u>150,000</u>
<input type="radio"/> \$70.51	<u>200,000</u>

Cost per Pay Period: 

Benefit Amount: 

- d. Complete your election by checking the radio button to apply for or decline the coverage and clicking “Next”.

Application riders

- ▶ Long Term Care (LTC) \$0.59
 Monthly Living Benefit (year 0) is \$504
- ▶ Benefit Restoration (BRR) \$0.09
- ▶ EZ Value (EZV) \$1 - 5 yrs ▾

Total Premium: \$6.00

- I wish to apply for this coverage
- I wish to DECLINE this coverage

Back

Next

- e. At the next screen, confirm your beneficiary choices and click “Next.”

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	+
Spouse Test	Spouse	<input checked="" type="checkbox"/> 100.00%	<input type="checkbox"/> 0.00%	✎ ✕
Child Test	Child	<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	✎ ✕
All Living Children		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	✎ ✕
Estate		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	✎ ✕

Back

Next

- f. Select “I do wish to CONFIRM changes” and click “Next” to complete the process and accept the changes made or select “I wish to CANCEL changes made in this enrollment session” to discard the changes and maintain your original level of coverage.

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	
Hartford Test	Employee	10/14/1980		12,590	\$6.00	HHC BRR EZVFP	Withdraw

i You may 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
Test Hartford	Spouse	F	10/14/1982	
Tester Hartford	Child	F	10/14/2018	

- I do wish to CONFIRM changes
 I wish to CANCEL changes made in this enrollment session.

[Back](#)

[Next](#)

- g. If you are electing coverage for the first time, you will come to this screen. Enter a phone number and choose “I wish to apply for this coverage.” You will then be asked several health-related questions.

Contact Info

Mobile Phone:

Why are we asking for your email address?
 PERSONAL EMAIL:

- I wish to apply for this coverage
 I wish to DECLINE this coverage

[Back](#)

[Next](#)

- h. If you have reviewed the information, but have decided to decline the coverage, choose the option “I wish to CANCEL changes made in this enrollment session” and then click Next to have your declination of the coverage saved.

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	
Age65 Test	Employee	8/16/1953		15,000	\$39.76	HHC BRR	Withdraw

i You may 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	Spouse	F	5/12/1992	
Child Test	Child	F	8/16/2017	

- I do wish to CONFIRM changes
 I wish to CANCEL changes made in this enrollment session.

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[Next](#)

14. When you are reviewing your Voluntary Term Life, you will be able to use the slider bar to review different amounts of coverage and the cost per pay period. Amounts that are subject to underwriting will be shown in red.

- i. If you are currently enrolled in Voluntary Life coverage for yourself, you can increase your coverage by 1 or 2 increments of \$10,000 up to the \$150,000 Guarantee Issue amount. If you are not currently enrolled and would like to add coverage or you are currently enrolled with over \$150,000 in Voluntary Life coverage and would like to increase your coverage, any enrollments or increases would be subject to Evidence of Insurability by The Hartford.
- j. If you are currently enrolled in Voluntary Spouse Life coverage, you can increase coverage by 1 or 2 increments of \$5,000 up to the \$30,000 Guarantee Issue amount. If you are not currently enrolled and would like to add coverage for your spouse, or if your spouse is currently enrolled with over \$30,000 in Voluntary Spouse Life coverage, any enrollments or increases would be subject to Evidence of Insurability by The Hartford.

Employee Voluntary Term Life

Why Life Insurance?



Learn More

Product Information



Customer Reviews

See what others are saying about The Hartford



If you die, life benefits are disbursed to your beneficiaries (a person, trust or organization you choose) in a lump sum to help them pay for things like:

- Burial and final expenses.
- Debts such as student and car loans and the mortgage.
- Future expenses, including college tuition, childcare, and retirement savings.

Your Employer's Plan Details

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

If you are currently enrolled in Voluntary Life coverage for yourself, you can increase your coverage by 1 or 2 increments of \$10,000 up to the \$150,000 Guarantee Issue amount. If you are not currently enrolled and would like to add coverage or you are currently enrolled with over \$150,000 in Voluntary Life coverage and would like to increase your coverage, any enrollments or increases would be subject to Evidence of Insurability by The Hartford.

Benefit Amount :  \$20,000

Cost per pay period: \$1.80

You have elected an amount that will be subject to underwriting.

- I wish to apply for this coverage
- I wish to cancel this coverage

Back

Employee Voluntary Term Life is now unlocked for editing. Click *No Change* to undo your changes.

No Change

Next

- When you reach the end of the plans available to review, you will be asked to sign and submit to confirm your elections. After reviewing what's on the screen and the total pre-tax and post-tax costs, if everything looks correct, click "next" in the upper or lower right-hand corner of the screen.



Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your pre-tax and post-tax contributions **per pay period** 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	Employer Paid
Health	CIGNA - Buy Up PPO Plan (\$0 Deductible); EO	\$89.90	\$0.00	\$371.84
Health Savings Account	N/A			
Critical Illness	Waived			
Accident Coverage	Plan 1; Family	\$0.00	\$12.21	\$0.00
Health Care FSA	Waived			
Dependent Care FSA	Waived			
Limited FSA	N/A			
Dental	CIGNA Dental; FA	\$9.01	\$0.00	\$38.08
Vision	MetLife Vision; FA	\$1.43	\$0.00	\$5.70
Basic Life	Basic Life - Hartford; \$40,000	\$0.00	\$0.00	\$1.89
Basic AD&D	Basic AD&D - Hartford; \$40,000	\$0.00	\$0.00	\$0.37
Dependent Group Life	\$3,000	\$0.00	\$0.00	\$0.56
Trustmark Universal Life	Waived			
Employee Voluntary Term Life	Waived			
Spouse Voluntary Term Life	Waived			
Child Voluntary Term Life	Waived			
Employee AD&D/Employee + Family AD&D	25,000; EO	\$0.00	\$0.35	\$0.00
Short-term Disability	Self-Funded; \$461.54	\$0.00	\$0.00	\$0.00
Long-term Disability	Long Term Disability - Hartford; \$2,000	\$0.00	\$0.00	\$3.69
EAP	EAP; EO	\$0.00	\$0.00	\$1.92
Total		\$100.34	\$12.56	\$421.73

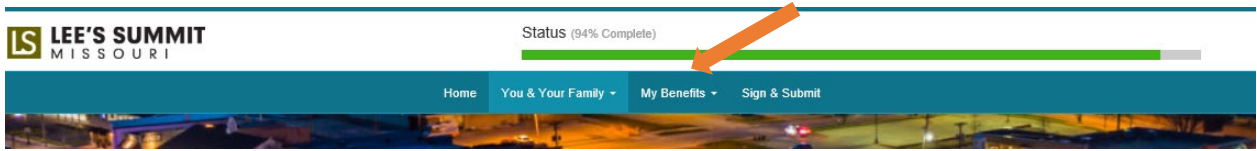
Signatures Required

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

Form Name	Status	Date Signed/Reviewed
City of LS - Benefit Confirmation	Unsigned	



16. If you change your mind on an election, or something doesn't look correct, the quickest way to go back is to use the drop-down menu under "My Benefits" to go directly to the section you want to unlock and change.



17. When you are finished reviewing your coverages and are ready to complete your enrollment, click next and go to the review/sign forms page. Fill in the PIN and click "Sign Form." Your PIN will be the same that you used to log in – last 4 digits of your SSN plus the last 2 digits of your birth year. You will receive an email confirmation of your enrollment.



- Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your pre-tax and post-tax contributions **per pay period** 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.

LEE'S SUMMIT MISSOURI **Benefit Confirmation / Deduction Authorization**

Name Test Employee	Date of Birth 02/01/1967	Home Phone (816) 969-2254	Work Phone	Address 123 Main St Kansas City, MO 64012
Employee ID 101031	Hire/Elig Date 03/02/2022	Gender M	E-mail Address test.employee@gmail.com	Reason for Completing Form Open Enrollment
Location CITY HALL		Department Development Services		
Job Class Full-Time		Title Planner		

Benefit Plan	Option	Cvg	Ded Cycle	Effective Date	Benefit Amount	Requested		Employee Cost		Employer Cost
						Benefit	Cost	Pre-tax	After-tax	
Health	CIGNA - Buy Up PPO Plan (\$1	EO	26	01/01/2023				89.90	0.00	371.84
Critical Illness	Waived									
Accident Coverage	Voluntary Accident	FA	26	01/01/2023				0.00	12.21	0.00
Health Care FSA	Waived									
Dependent Care FSA	Waived									
Dental	CIGNA Dental	FA	26	01/01/2023				9.01	0.00	36.06
Vision	MetLife Vision	FA	26	01/01/2023				1.43	0.00	5.70
Basic Life	Basic Life - Hartford	EO	26	01/01/2023	40,000			0.00	0.00	1.59
Basic AD&D	Basic AD&D - Hartford	EO	26	01/01/2023	40,000			0.00	0.00	0.37
Dependent Group Life	Dependent Group Life - Hartfo	SC	26	01/01/2023	3,000			0.00	0.00	0.56
Trustmark Universal Life	Waived									
Employee Voluntary Term L	Waived									
Employee AD&D/Employee	Employee AD&D/Employee +	EO	26	01/01/2023	25,000			0.00	0.35	0.00
Short-term Disability	Self-Funded	EO	26	01/01/2023	462			0.00	0.00	0.00
Long-term Disability	Long Term Disability - Hartfor	EO	26	01/01/2023	2,000			0.00	0.00	3.69
EAP	EAP	EO	26	01/01/2023				0.00	0.00	1.92

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

PIN:

18. Once you have submitted your enrollment and see the “Sign & Submit” screen, you will see “Congratulations! Your enrollment is now complete.”



Congratulations! 

Your enrollment is now complete. You may log-in to the system at any time during the year to review your benefit elections.

Recap of Your Elections

Listed below is a recap of your elections including who is covered under each benefit plan and your named beneficiaries. Scroll down to the bottom of this screen to view a list of your completed enrollment forms.

19. You may download the form to your computer or print by scrolling to the bottom of this page and clicking the hyperlink “City of LS Benefit Confirmation” and then downloading the form that opens.

Completed Forms

Following is a list of forms reviewed and/or signed during the enrollment. Click on the form name to view or print.
Press *Logout* to exit the website.

Form Name	Date Signed/Reviewed
 City of LS - Benefit Confirmation 	10/11/2019

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