



Online Benefits Website

User Guide

for

Employees

Table of Contents

ACCESSING MESSA'S ONLINE BENEFITS WEBSITE	3
First Time Logging Into MESSA.org.....	3
Active MESSA.org Account	7
HOME PAGE	9
NEW HIRE	10
VIEWING/EDITING PERSONAL INFORMATION	17
VIEWING/EDITING DEPENDENT INFORMATION	18
BENEFICIARIES.....	19
QUALIFYING EVENTS / ENROLLMENT CHANGES	22
Birth	22
Marriage	31
Divorce.....	40
Legal Guardianship	49
Adding a Dependent.....	58
Removing a Dependent from ALL Benefits.....	68
Removing a Dependent from PARTIAL Benefits	77
Adding a Spouse	86
Removing a Spouse.....	96
Adding Medical.....	105
Removing Medical	114
Spouse or Child Death	121
ELECTING BENEFITS	121
CANCELLING MESSA BENEFITS.....	130
CONFIRMATION STATEMENTS.....	130
EMPLOYEE FILE DOCUMENTS	132
UPLOADING DOCUMENTS.....	132
VIEWING UPLOADED DOCUMENTS	133
QUESTIONS	134

OVERVIEW

MESSA has partnered with a leading industry enrollment vendor to provide an Online Enrollment Website for your school business offices and you. MESSA's online enrollment website is user-friendly and is designed to assist you in updating your benefits, family statuses and job changes.

What this means for you:

- Information. You can see your benefit and enrollment options, review and update personal and family information.
- Convenience. The site is accessible 24/7 wherever there is an internet connection.

If you have any questions, please contact the MESSA Member Service Center at 800.336.0013.

Employee Responsibilities

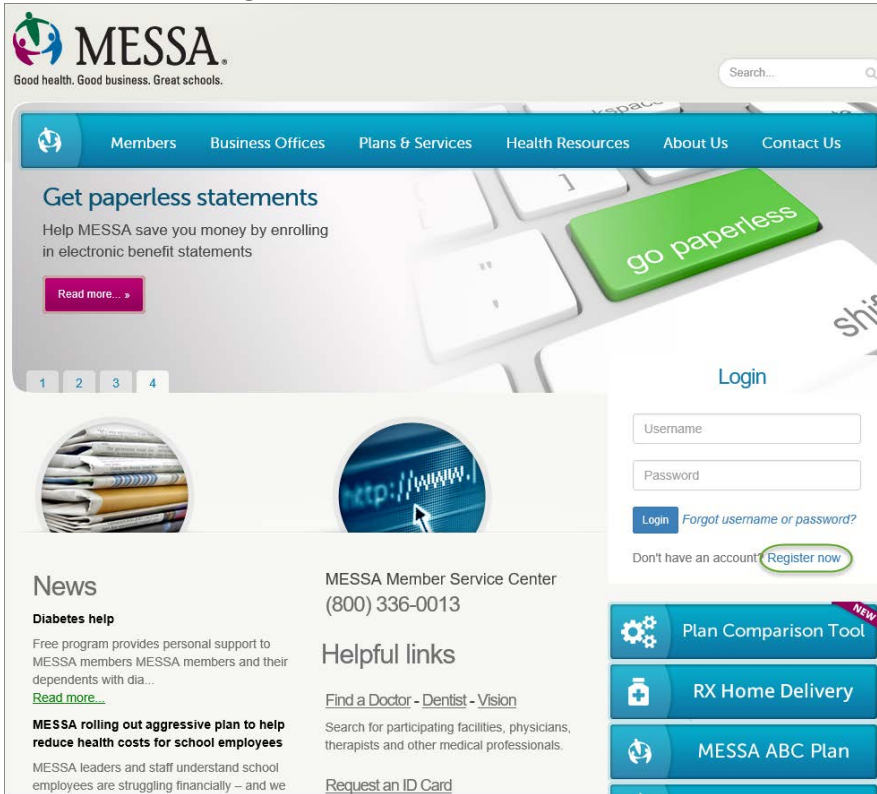
- Once your information has been added to MESSA's online enrollment website by your employer, you will receive an email notifying you that you can log into the online benefits website using the www.messa.org employee portal. (For Newly Hired Employees)
- You will need to verify your demographic (personal) information, add or update your dependent information and elect your benefits.
- All benefit elections will be sent to your employer for approval.

ACCESSING MESSA'S ONLINE BENEFITS WEBSITE

The online benefits website is available 24 hours a day, seven days a week for you to enter and review your contact information, benefit enrollment information, eligible dependents, beneficiaries and more.

[First Time Logging Into MESSA.org](#)

- Open the MESSA website by going to www.messa.org.
- Click on **“Register Now.”**



- Enter the following information to create a messa.org account:
 - Last four digits of your Social Security Number
 - Date of birth
 - Employer
 - Home zip code
- Click **“Next.”**

The screenshot shows the "My MESSA" registration page, specifically "Step 1: User information". The form has four input fields: "Enrollee ID/SSN (last 4 digits)", "Employer" (a dropdown menu with "A01-Unknown Or Unassigned" selected), "Date of birth", and "Home zip code". Each of these four fields is circled in green. At the bottom right of the form is a blue "Next" button.

- Select your security questions and enter your answers.
- Click **“Next.”**

My MESSA.

Registration

✔ User Validated

Step 2: Security Questions

Question 1
Select a question... ▼

Answer 1
[Text Input]

Question 2
Select a question... ▼

Answer 2
[Text Input]

Question 3
Select a question... ▼

Answer 3
[Text Input]

Question 4
Select a question... ▼

Answer 4
[Text Input]

Question 5
Select a question... ▼

Answer 5
[Text Input]

Next

Why register?

You can:

- View deductibles, claims and explanation of benefits statements
- Find doctors, hospitals and other providers
- Show your virtual ID card
- Securely contact MESSA's award-winning customer support
- Access your account anytime and anywhere

- A confirmation code will be sent to the email address you used when creating your account.
- Enter the Confirmation code.
- Click **“Confirm.”**

My MESSA.

Welcome to MESSA!

Please enter the confirmation code sent to [Redacted] for registration confirmation in the box below and select "Confirm".

To resend the code select "Resend".

Confirmation code

[Text Input]

Resend **Confirm**

1. Create a username.
2. Create a password.
3. Confirm your password.
4. Click the “I’m not a robot” box.
5. Enter your email address.
6. Confirm your email address
7. Check the “I agree to the MESSA Web Terms of Use” box and check the “Yes, send my EOB statements electronically” box if you’d like your Explanation of Benefits emailed to you.
- Click **“Register now”**.

800.336.0013

Username Password Login Search...

My MESSA

Registration

User Validated
 Security Questions Accepted

Step 3: Username and Password

1 Username


 Suggestion: Ejohansson

Your password must be at least eight characters in length and MUST contain AT LEAST

- One uppercase letter
- One lowercase letter
- One number
- One special character (e.g., =!@#%&*!._+)

2 Password

3 Confirm password

4 I'm not a robot 

5 Email

6 Confirm email

Go paperless!

You can receive your Explanation of Benefits statements electronically and be notified by email, instead of by postal mail. You can change back to paper statements any time by changing your [account preferences](#).

7 Yes, send my EOB statements electronically. [Learn more](#)
 I agree to the [MESSA Web Terms of Use](#)

Register now

- Once logged in to your account, click on the **“Online benefits website”** link in the box on the left side of the screen. (If you do not see this link, logout and log back in and it will appear.)
- The Employee User Guide link is located under the **“Online benefits website”** link. This user guide will give you step by step instructions.

The screenshot shows the My MESSA website interface. At the top, there are navigation links: HOME, BENEFITS, CLAIMS, MANAGE ACCOUNT, and CONTACT US. The main content area is titled 'Deductible' and 'Out-of-pocket'. It displays 'Family deductible progress' with a gauge showing \$321.48 Met out of a \$4,000 Total. Below this, it shows '\$321.48 Met' and '\$3,678.52 Remaining'. There are also tabs for 'Current year' and 'Previous year', and radio buttons for 'In-network' and 'Out-of-network'. On the left sidebar, there are links for 'Online benefits website' (highlighted with a green circle) and 'Employee user guide' (also highlighted with a green circle). Below the sidebar, there is a 'SUMMARY' section with a table of claim totals.

Claim totals	Amount billed	MESSA coverage		Member responsibility	
		Provider savings	MESSA payment	Deductible	Copayment/ coinsurance
Total Medical	\$630.11	\$339.48	\$0.00	\$290.63	\$0.00
Total Pharmacy	\$74.91	\$44.06	\$0.00	\$30.85	\$0.00
Totals	\$705.02	\$383.54	\$0.00	\$321.48	\$0.00

- You will receive a pop-up letting you know that you are going to another web site.
- Click **“Continue.”**
- This will take you directly to MESSA’s Online Benefits Website.

The screenshot shows a pop-up window with a blue header that says 'Go to Another Web Site' and a close button (X). The main text reads: 'You Are Going to Another Web Site. You are going to a Web site that is not affiliated with MESSA and may offer a different privacy policy and level of security. MESSA is not responsible for and does not endorse, guarantee or monitor content, availability, viewpoints, products or services that are offered or expressed on other Web sites. If you logged into the secure MESSA Member area, your secure session may time out while you are visiting another Web site.' At the bottom, there are two buttons: 'Continue' (highlighted with a green circle) and 'Cancel'.

- Once you have completed creating your MESSA.org account and are on the online benefits website, see the **“New Hire”** section in this guide for instructions on how to enroll in benefits.

Active MESSA.org Account

- Go to www.messa.org and log in using your current username and password.

The screenshot shows the MESSA.org website homepage. At the top left is the MESSA logo with the tagline "Good health. Good business. Great schools." and a search bar. A blue navigation bar contains links for "Members", "Business Offices", "Plans & Services", "Health Resources", "About Us", and "Contact Us". Below the navigation is a banner for "Get paperless statements" with a "Read more..." button. To the right is a "Login" form with fields for "Username" and "Password", a "Login" button, and a link for "Forgot username or password?". Below the login form are buttons for "Plan Comparison Tool", "RX Home Delivery", and "MESSA ABC Plan". On the left side, there are "News" sections for "Diabetes help" and "MESSA rolling out aggressive plan to help reduce health costs for school employees", along with "Helpful links" for "Find a Doctor - Dentist - Vision" and "Request an ID Card".

- If you have forgotten your password or are having trouble logging in, please click on “**Forgot Username or Password?**”
- If you are still unable to log in, contact MESSA’s Member Service Center at 800.336.0013.

This screenshot is identical to the one above, but with a red rectangular box highlighting the "Forgot username or password?" link in the login form. The rest of the page content, including the navigation bar, banners, and service buttons, remains the same.

- Once you are logged into MESSA’s secure member portal, click on the “**Online benefits website**” link in the box on the left side of the screen.

My MESSA | HOME | BENEFITS | CLAIMS | MANAGE ACCOUNT | CONTACT US

messa ABC Plan 2

Enrollee ID: [REDACTED]
Employer(s): [REDACTED]
Effective date(s): 5/1/2017

Additional family members: [REDACTED]

HSA balance: [REDACTED] | View your account >

Online benefits website (circled in green)

Employee user guide (circled in green)

View EOB statements
Find a doctor
Rx home delivery
Secure messaging
Request ID card
Virtual ID card

Deductible | Out-of-pocket

Current year | Previous year | In-network | Out-of-network

Family deductible progress

\$4,000 Total

\$321.48 Met

\$0 | Met | \$4,000

\$3,678.52 Remaining

SUMMARY
View all deductible claims >

Claim totals	Amount billed	MESSA coverage		Member responsibility	
		Provider savings	MESSA payment	Deductible	Copayment/ coinsurance
Total Medical	\$630.11	\$339.48	\$0.00	\$290.63	\$0.00
Total Pharmacy	\$74.91	\$44.06	\$0.00	\$30.85	\$0.00
Totals	\$705.02	\$383.54	\$0.00	\$321.48	\$0.00

- You will receive a pop-up letting you know that you are going to another web site.
- Click “**Continue.**”
- This will take you directly to MESSA’s Online Benefits Website.

Go to Another Web Site
✕

You Are Going to Another Web Site

You are going to a Web site that is not affiliated with MESSA and may offer a different privacy policy and level of security. MESSA is not responsible for and does not endorse, guarantee or monitor content, availability, viewpoints, products or services that are offered or expressed on other Web sites.

If you logged into the secure MESSA Member area, your secure session may time out while you are visiting another Web site.

Continue

Cancel

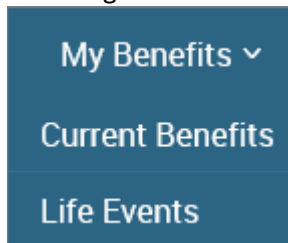
HOME PAGE

This website has been created to provide you with information about your benefits. You will have the ability to enroll online and update your personal and dependent information. The tabs at the top of the page have the following information:



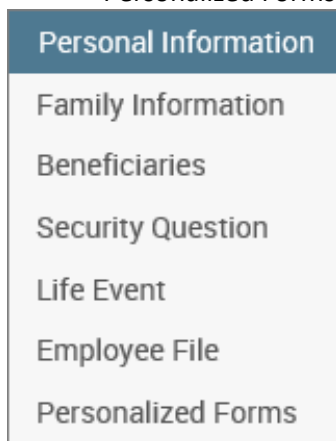
My Benefits

- Current Benefits – shows the details of all current benefits.
- Life Events – used to create an enrollment window if you have a qualifying event (within MESSA’s eligibility guidelines of 30 days) that allows benefit changes.



My Profile

- Personal Information – View/edit address information
- Family Information – View/edit dependent information
- Beneficiaries – View/edit beneficiary information
- Security Question – Change security questions
- Life Event – Create a “Life Event” (see page 23 for instructions).
- Employee File – Upload documents to your Employee File
- Personalized Forms – View a confirmation statement for any effective date



User Guide

- The “Online Benefits Website User Guide for Employees” will open in another web window. This provides instructions on how to use MESSA’s Online Benefits Website.

NEW HIRE

- Click on the “**Start Your Enrollment**” button to begin.

Welcome to your New Hire Enrollment!

Enrollment Deadline **7/2/2017**

Your Status **Not Started**

Start Your Enrollment

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name
Middle Initial
* Last Name
Suffix
Social Security Number
* Date of Birth
* Gender Male Female

* Fields are required

Address

Address 1
Address 2
City
State
Zip
Home Phone
Cell Phone
Home Email

WORK CONTACT INFORMATION

Work Phone
Work Phone Ext.
* Work Email
Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

- Employee Information
- Family Info
- Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-889-4167.

Mel Tester

Female Employee

36 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)


Markese Tester

Male Son

27 years old (8/6/1985)

SSN: [REDACTED]

[Edit >](#)



[Add Dependents](#)

1 Your Info

Employee Info

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
Dental - Dent 80/80/80/80:1300(1500)
Vision - VSP 2S
Negotiated LTD
PAK Life - \$50,000 PAK Life
PAK AD&D - \$50,000 PAK AD&D
Basic Term Life - \$5,000

PAK B
Dental - Dent 80/80/80/80:1300(1500)
Vision - VSP 2S
Negotiated LTD
PAK Life - \$50,000 PAK Life
PAK AD&D - \$50,000 PAK AD&D

PAK C
Medical – MESSA ABC Plan 2
Dental - Dent 80/80/80/80:1300(1500)
Vision - VSP 2S
Negotiated LTD
PAK Life - \$50,000 PAK Life
PAK AD&D - \$50,000 PAK AD&D
Basic Term Life - \$5,000

PAK D
Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
Dental - Dent 80/80/80/80:1300(1500)
Vision – VSP 2S
Negotiated LTD
PAK Life - \$50,000 PAK Life
PAK AD&D - \$50,000 PAK AD&D
Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info
Employee Information
Family Info
Questions


2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

 **Medical** NO PLAN SELECTED

*Selection Required **View Plan Options**

- Once you have clicked on “View Plan Options” you will be presented with the dependent screen. This screen will only appear for the benefits that dependents can be enrolled in.
- To cover a dependent, check the box next to their name.
- To remove a dependent, uncheck the box next to their name.
- Click “Continue”.

Who will be covered by this plan?

Gabriel Test Employee
 Paige Test Spouse
 Jason Test Son

[+ Add Dependents](#)

Covered
Not Covered

[Back to Benefits](#)
Continue

- Select the benefit plan by clicking “Select”.

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

[View plan details](#)
[Plan Brochure](#)

Your Cost per month:
\$15.00 ▼
Tier: Employee

Select

- When finished going through every benefit plan, click “Continue” on the right-hand side.

1 Your Info
2 **Your Benefits**
3 Enroll
4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

Continue

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

Save and Finish Later

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries](#) (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

4 Complete

Your Cost per month **\$50.00**

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00** Per Month

Medical Your cost per month **\$0.00**

⚠ This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:

Name	Relationship	Coverage
Test User	Employee	✓ Cover
Spouse User	Spouse	✓ Cover

Your Cost **\$0.00**

1 Your Info
2 Your Benefits
3 Enroll
Beneficiaries
Other Coverages
Review and Confirm
4 Complete

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

1 Your Info
2 Your Benefits
3 Enroll
Beneficiaries
Other Coverages
Review and Confirm
4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

✓ Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

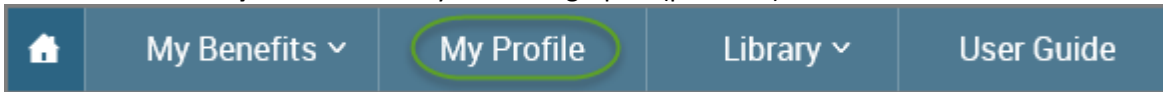
Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW EMAIL PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

VIEWING/EDITING PERSONAL INFORMATION

- Click on **“My Profile”** to see your demographic (personal) information.




- If you need to make changes to any information, click on the **“Edit”** button next to the panel title that you need to make changes to.

Personal Information

Demographics

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

 Gabriel Test

Demographic Information

[Edit](#)

First Name Gabriel
Middle Initial
Last Name Test
Suffix
Social Security Number
Date of Birth 1/1/1985
Age 32
Gender Male

Address Information

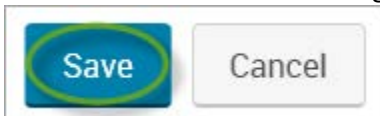
[Edit](#)

Address 1 1475 Kendale Blvd
Address 2
City East Lansing
State MI
Zip 48823
Home Phone 517-332-2581
Cell Phone
Home Email

Work Contact Information

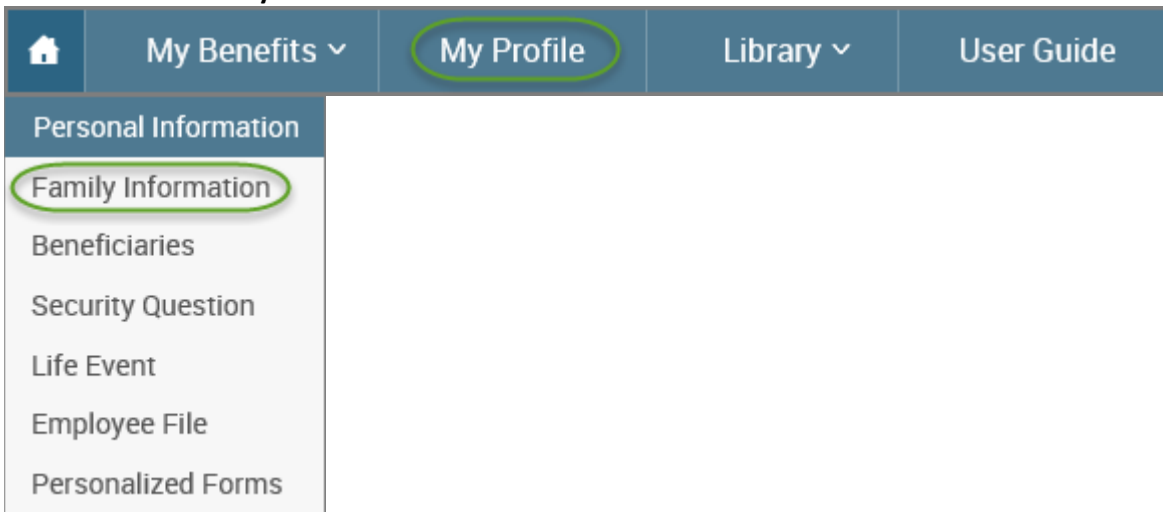
Work Phone
Work Phone Ext.
Work Email gabrieltest@work.com

- Click **“Save”** once changes are made.



VIEWING/EDITING DEPENDENT INFORMATION

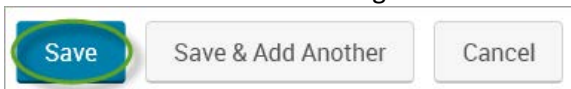
- Click on **“My Profile”** to see your demographic (personal) information.
- Select **“Family Information.”**



- If you need to make changes to your dependent information, click on the **“Edit>”** button.

A screenshot of a form titled 'Spouse Test'. The form has a white background and a thin border. It contains the following text: 'Spouse Test' (title), 'Male Spouse', '36 years old (1/1/1980)', and 'SSN: [redacted]'. At the bottom left of the form, there is a blue button with the text 'Edit >' (circled in green).

- Click **“Save”** once changes are made.

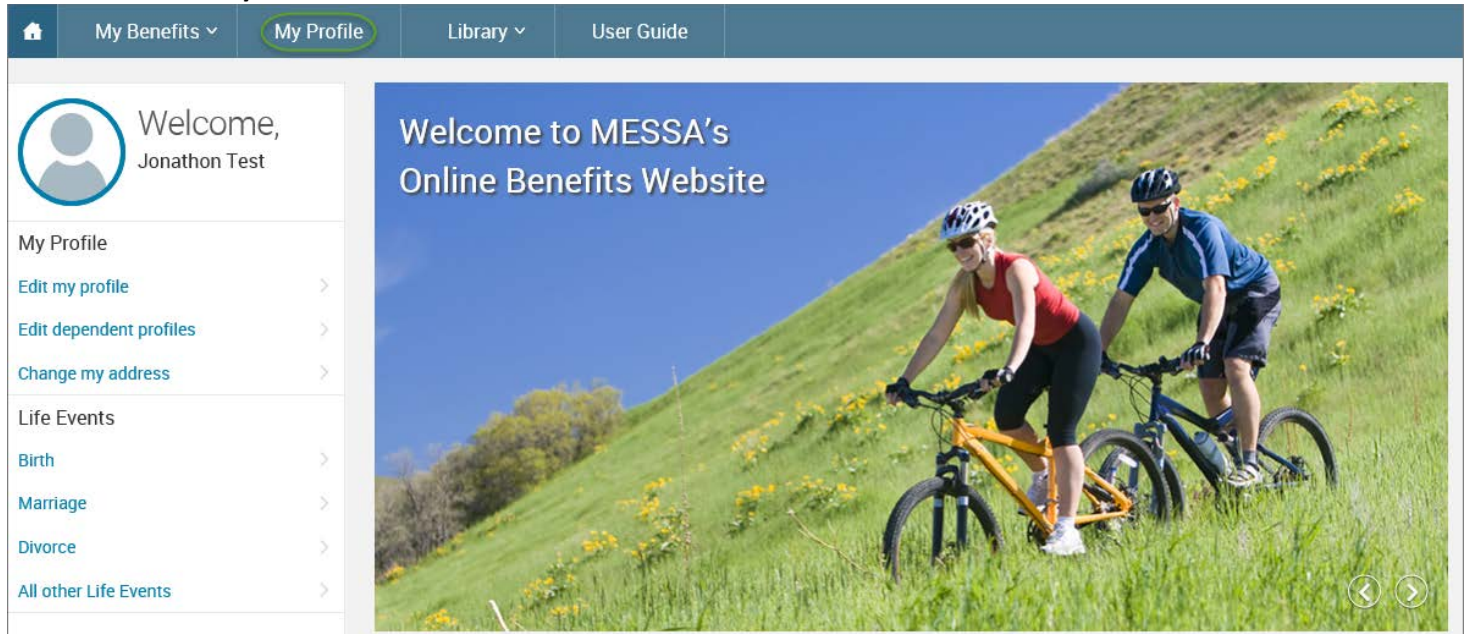


NOTE: If you need to add or delete dependents to coverage see *“Qualifying Events/Enrollment Changes”* on page 23.

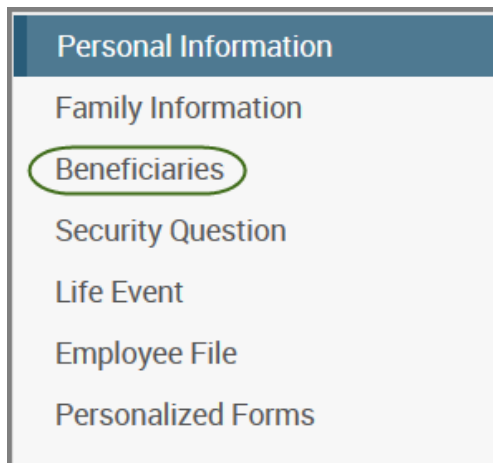
BENEFICIARIES

When you have life insurance with MESSA, whether it be Negotiated Life Insurance or Optional Life Insurance, a Beneficiary Designation is required. You are able to update beneficiary information without having to make changes to your benefits.

- Click on **“My Profile.”**



- Click on **“Beneficiaries”**.



- At least one primary beneficiary for each life insurance policy must be designated.
 - Basic Term Life & Supplemental Term Life Insurance is entered under the “Basic Term Life” section.
 - Negotiated/PAK & AD&D Life Insurance is entered under the “Negotiated Life” section.
- The dependents that you have listed on your account will automatically be listed.
- Designation percentage must equal 100%.
- Make necessary changes and click **“Save”**.

Beneficiaries

Gabriel Test

A beneficiary is a person or entity that is designated as the recipient of funds under your eligible insurance policies. PRINT
Please review your designated beneficiaries below.

Relationship	Name
(Employee)	My Estate
(Spouse)	Paige Test
(Son)	Jason Test

[+ Add Beneficiary](#)

Beneficiary Designation

Basic Term Life

Beneficiaries

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Paige Test (Spouse)	<input type="text" value="100.0"/> %
Jason Test (Son)	<input type="text"/> %

Total: 100%

Negotiated Life

Beneficiaries

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Paige Test (Spouse)	<input type="text" value="100.0"/> %
Jason Test (Son)	<input type="text"/> %

Total: 100%

[v Add Secondary Beneficiaries \(optional\)](#)

Save

Cancel

- You will receive the following message:

 **Beneficiary Designation information was saved successfully.**

- You may add a beneficiary by clicking on the “**Add Beneficiary**” link.
- The only fields that are required are the “**Relationship**” and the “**Name/Trust Name**” fields.
- Once you add a beneficiary, click “**Save**”.
- Now you will be able to designate a percentage to the beneficiary that was added.

Beneficiary Maintenance

* Relationship

* Name/Trust Name

Trust's Full Name

Text: no more than 1,000 characters

Trust Account Number

Social Security Number

Date of Birth

Home Address 1

Home Address 2

City

State

Zip

Phone

* Fields are required

Save

Save & Add Another

Cancel

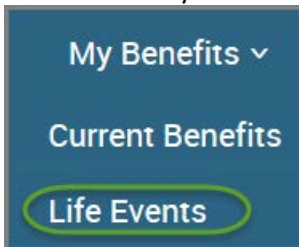
QUALIFYING EVENTS / ENROLLMENT CHANGES

- When you have a qualifying event **within 30 days***, a “Life Event” will need to be created to be able to make benefit and/or dependent changes to your policy.
- Directions on how to create a Life Event for each qualifying event are below.
- After creating the Life Event, enrollment **MUST** be completed in order to make the benefit/dependent changes.

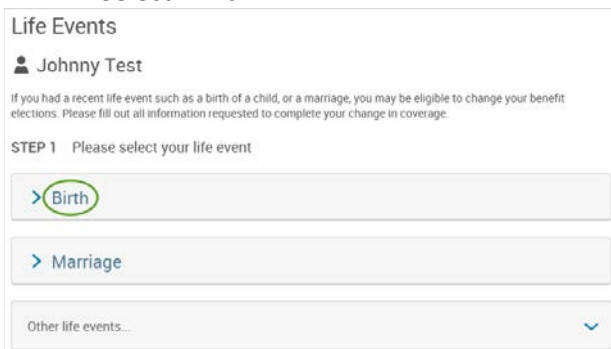
****If the Life Event is outside of MESSA’s eligibility guidelines of 30 days, you will need to contact your Benefits Administrator for further assistance.***

Birth

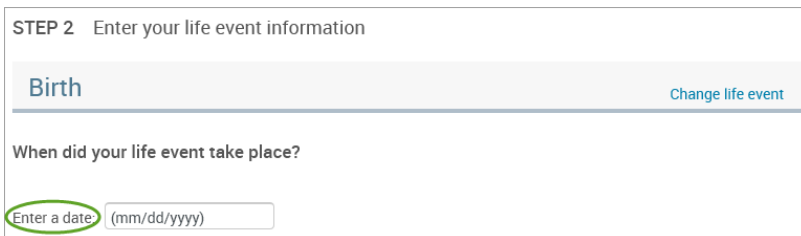
- Hover your cursor over the “**My Benefits**” tab at the top of the screen and choose “**Life Events.**”



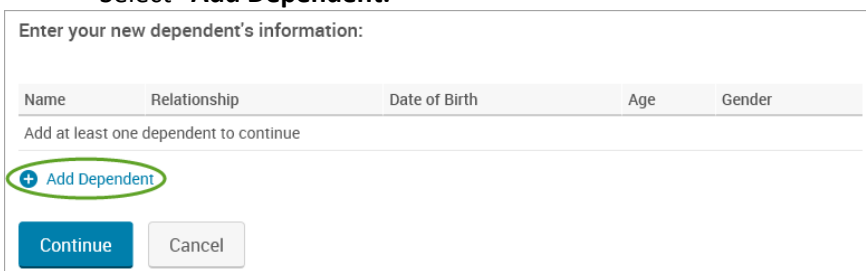
- Select “**Birth.**”

A screenshot of the 'Life Events' selection screen. The title is 'Life Events' and the user is identified as 'Johnny Test'. Below the title is a message: 'If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.' The screen is labeled 'STEP 1 Please select your life event'. There are three buttons: '> Birth' (circled in green), '> Marriage', and 'Other life events...' with a downward arrow.

- Enter newborn’s birthdate.

A screenshot of the 'STEP 2 Enter your life event information' screen. The title is 'STEP 2 Enter your life event information'. Below the title is a button labeled 'Birth' and a link labeled 'Change life event'. Below that is the question 'When did your life event take place?'. There is a text input field with the placeholder text 'Enter a date: (mm/dd/yyyy)' circled in green.

- Select “**Add Dependent.**”

A screenshot of the 'Enter your new dependent's information' screen. The title is 'Enter your new dependent's information:'. Below the title is a table with columns: Name, Relationship, Date of Birth, Age, and Gender. Below the table is the text 'Add at least one dependent to continue'. There is a button labeled '+ Add Dependent' circled in green. At the bottom are two buttons: 'Continue' and 'Cancel'.

- Enter newborn’s demographic information.
- Click **“Save.”**

Add Family Member

Dependent Demographic

* First Name

Middle Initial

* Last Name

Suffix

* Date of Birth

Social Security Number

* Gender Male Female

* Relationship

* Fields are required

- Click **“Continue.”**

Enter your new dependent’s information:

Name	Relationship	Date of Birth	Age	Gender
Baby Test	Daughter	7/5/2016	0	F

[+ Add Dependent](#)

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Birth [Change life event](#)

Life Event: **Birth**

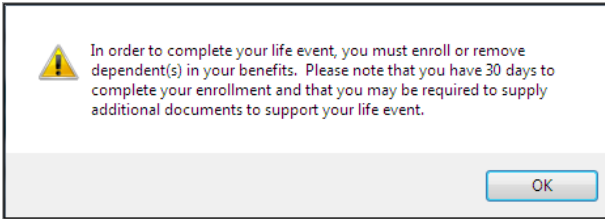
Date of Event: **07/05/2016**

Added to Family: **Baby Test**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**



- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the **“I agree”** box.
- Click **“Continue”**.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box "I Agree" below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the "+ Add Dependents" link. To verify or edit the information of a family member who has already been entered, click on the person's name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Baby Test

Female Daughter

0 years old (5/15/2017)

[Edit >](#)

Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

[Edit >](#)

+

Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child's spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

- 1 Your Info
- Employee Information
- Family info
- Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info
 Employee Information
 Family Info
Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 v

Your Cost per month

PLAN MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Check the newborn’s name and click **“Continue”**.

Who will be covered by this plan?

John Test
Employee

Sally Test
Spouse

Baby Test
Daughter

Johnny Test
Son

[+ Add Dependents](#)

[← Back to Benefits](#) [Continue](#)

- Select the benefit plan by clicking **“Select”** or **“Keep Selection”**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)

[Plan Brochure](#)

Your Cost per month:
\$25.00

Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

1 Your Info

2 **Your Benefits**

3 Enroll

4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries](#) (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

4 Complete

Your Cost per month \$50.00

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

Medical

Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Your Cost **\$0.00**

Who will be covered on this plan:		
Name	Relationship	Coverage ⓘ
Test User	Employee	✔ Cover
Spouse User	Spouse	✔ Cover

1 **Your Info**

2 **Your Benefits**

3 **Enroll**

4 **Complete**

Beneficiaries

Other Coverages

Review and Confirm

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

✔ **I agree, and I'm finished with my enrollment**

1 **Your Info**

2 **Your Benefits**

3 **Enroll**

4 **Complete**

Beneficiaries

Other Coverages

Review and Confirm

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

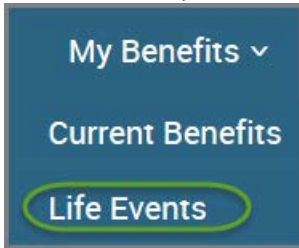
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Marriage

- Hover your cursor over the **“My Benefits”** tab at the top of the screen and choose **“Life Events.”**



- Select **“Marriage.”**

Life Events


 Suzy Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> **Marriage**

Other life events... 

- Enter the date of marriage.

STEP 2 Enter your life event information

Marriage [Change life event](#)

When did your life event take place?

Enter a date:

- Select **“Add Dependent.”**

Enter your new dependent's information:

Name	Relationship	Date of Birth	Age	Gender
Add at least one dependent to continue				
+ Add Dependent				

- Enter spouse’s demographic information.
- Click **“Save.”**

Add Family Member

Dependent Demographic

* First Name

Middle Initial

* Last Name

Suffix

* Date of Birth

* Social Security Number

* Gender Male Female

* Relationship

* Fields are required

Save

- Click **“Continue.”**

Enter your new dependent’s information:

Name	Relationship	Date of Birth	Age	Gender
Spouse Test	Spouse	1/1/1980	36	M

Add Dependent

Continue Cancel

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Marriage [Change life event](#)

Life Event: **Marriage**

Date of Event: **08/06/2016**

Added to Family: **Spouse Test**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

Save and Start Life Event Enrollment Cancel

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

OK

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “I agree” box.
- Click “Continue”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box "I Agree" below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Baby Test

Female Daughter

0 years old (6/15/2017)

[Edit >](#)

Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

[Edit >](#)

+

[Add Dependents](#)

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

- 1 Your Info
 - Employee Information
 - Family Info
 - Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 ▾

Your Cost per month

PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan /

[View plan details](#)

COVERAGE

Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Check the spouse’s name and click “Continue”.

Who will be covered by this plan?

Susan Test
Employee

Spouse Test
Spouse

Child Test
Daughter

[+ Add Dependents](#)

[← Back to Benefits](#) [Continue](#)

- Select the benefit plan by clicking “Select” or “Keep Selection”.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)

[Plan Brochure](#)

Your Cost per month:
\$25.00

Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click “Continue” on the right-hand side.

1 Your Info

2 Your Benefits

3 Enroll

4 Complete

Your Cost per month \$50.00

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries](#) (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Beneficiaries

Other Coverages

Review and Confirm

Your Cost per month **\$50.00**

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost \$0.00
Per Month

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

Medical

Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:

Name	Relationship	Coverage
Test User	Employee	Cover
Spouse User	Spouse	Cover

Your Cost \$0.00

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

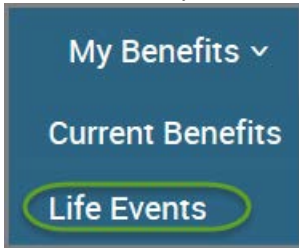
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Divorce

- Hover your cursor over the “My Benefits” tab at the top of the screen and choose “Life Events.”



- Select “Other life events...”

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select “Divorce.”


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the date of divorce.

STEP 2 Enter your life event information

Divorce [Change life event](#)

When did your life event take place?

Enter a date:

- Check the box next to the spouse’s name.
- Click **“Continue.”**

Update	Name	SSN	Relationship	Date of Birth	Age	Gender	Additional Information
	Joe Test		Employee	1/1/1980	36	M	
<input checked="" type="checkbox"/>	Spouse Test		Spouse	1/1/1980	36	F	
	Michael Test		Son	1/1/1989	27	M	

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Divorce [Change life event](#)

Life Event: **Divorce**


Date of Event: **08/05/2016**

Removed from Family: **Spouse Test**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**



In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN:

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN:

[Edit >](#)

Baby Test

Female Daughter

0 years old (6/15/2017)

[Edit >](#)


Johnny Test

Male Son

2 years old (1/1/2015)

SSN:

[Edit >](#)



Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

- 1 Your Info
 - Employee Information
 - Family info
 - Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info
 Employee Information
 Family Info
Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 ▼

Your Cost per month

PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE

Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Uncheck the spouse's name and click **"Continue"**.

Who will be covered by this plan?

Susan Test
Employee

Spouse Test
Spouse

Child Test
Daughter

[+ Add Dependents](#)

[← Back to Benefits](#)
[Continue](#)

- Select the benefit plan by clicking **"Select"** or **"Keep Selection"**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)
[Plan Brochure](#)

Your Cost per month:
\$25.00
 Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **"Continue"** on the right-hand side.

- 1 Your Info
- 2 **Your Benefits**
- 3 Enroll
- 4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries \(optional\)](#)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage

Coverage Level

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Complete Enrollment

♥
Medical
Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:

Name	Relationship	Coverage
Test User	Employee	✔ Cover
Spouse User	Spouse	✔ Cover

Your Cost **\$0.00**

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

✔ I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

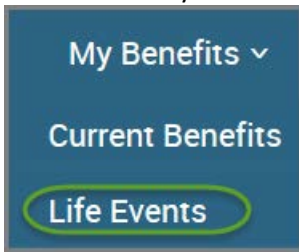
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Legal Guardianship

- Hover your cursor over the **“My Benefits”** tab at the top of the screen and choose **“Life Events.”**



- Select **“Other life events...”**

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select **“Legal Guardianship.”**


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter legal guardianship effective date.

STEP 2 Enter your life event information

Legal Guardianship [Change life event](#)

When did your life event take place?

Enter a date:

- Select **“Add Dependent.”**

Enter your new dependent’s information:

Name	Relationship	Date of Birth	Age	Gender
Add at least one dependent to continue				
+ Add Dependent				
<input type="button" value="Continue"/>		<input type="button" value="Cancel"/>		

- Enter legal guardian’s demographic information
- Click **“Save.”**

Add Family Member

Dependent Demographic

* First Name

Middle Initial

* Last Name

Suffix

* Date of Birth

* Social Security Number

* Gender Male Female

* Relationship

* Fields are required

- Click **“Continue.”**

Name	Relationship	Date of Birth	Age	Gender
Legal Guardian	Legal Guardianship	1/1/1999	17	M
+ Add Dependent				
<input type="button" value="Continue"/>		<input type="button" value="Cancel"/>		

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Legal Guardianship [Change life event](#)


Life Event: **Legal Guardianship**
Date of Event: **08/01/2016**
Added to Family: **Legal Guardian**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

Save and Start Life Event Enrollment Cancel

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

OK

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

Edit >

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

Edit >

Baby Test

Female Daughter

0 years old (5/15/2017)

Edit >

Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

Edit >

+

Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 ▼

Your Cost per month

PLAN MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Check the legal guardian’s name and click **“Continue”**.

Who will be covered by this plan?

Susan Test Employee
 Spouse Test Spouse
 Child Test Daughter
 Mark Tester Legal Guardianship
 [+ Add Dependents](#)

[← Back to Benefits](#)
Continue

- Select the benefit plan by clicking **“Select”** or **“Keep Selection”**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)
[Plan Brochure](#)

Your Cost per month:
\$25.00

Tier: Employee + Dependent

Keep Selection

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

- 1 Your Info
- 2 **Your Benefits**
- 3 Enroll
- 4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

Continue

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries \(optional\)](#)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▾

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▾

Coverage Level ▾

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

Medical

Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Your Cost **\$0.00**

Who will be covered on this plan:		
Name	Relationship	Coverage
Test User	Employee	Cover
Spouse User	Spouse	Cover

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

[Adding a Dependent](#)

- Hover your cursor over the “My Benefits” tab at the top of the screen and choose “Life Events.”



- Select “Other life events...”

Life Events

Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events...

- Select “Child Becomes Eligible.”

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events...

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the effective date (**first of the month**).

STEP 2 Enter your life event information

Child Becomes Eligible [Change life event](#)

When did your life event take place?

Enter a date: (mm/dd/yyyy)

- Check the “I verify that all of the above Life Event information is correct.” box.
- Click “Save and Start Life Event Enrollment.”

STEP 3 Confirm your information

Child Becomes Eligible [Change life event](#)


Life Event: **Child Becomes Eligible**
Date of Event: **08/01/2016**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

Save and Start Life Event Enrollment Cancel

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click “OK.”

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

OK

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Baby Test

Female Daughter

0 years old (6/15/2017)

[Edit >](#)

Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

[Edit >](#)

+

Add Dependents

- 1 Your info
- Employee Information
- Family info
- Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00

Your Cost per month

PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan /

[View plan details](#)

COVERAGE

Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Check the dependent’s name and click **“Continue”**.

Who will be covered by this plan?

Susan Test
Employee

Spouse Test
Spouse

Child Test
Daughter

Mark Tester
Legal Guardianship

[+ Add Dependents](#)

[← Back to Benefits](#) [Continue](#)

- Select the benefit plan by clicking **“Select”** or **“Keep Selection”**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)

[Plan Brochure](#)

Your Cost per month:
\$25.00

Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

1 Your Info

2 **Your Benefits**

3 Enroll

4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[➕ Add New Beneficiary](#)

[▼ Add Secondary Beneficiaries \(optional\)](#)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month \$50.00

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

- 1 Your Info
- 2 Your Benefits
- 3 **Enroll**
- 4 Complete

Complete Enrollment

Medical
Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Your Cost
\$0.00

Who will be covered on this plan:		
Name	Relationship	Coverage
Test User	Employee	✔ Cover
Spouse User	Spouse	✔ Cover

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 **Enroll**
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

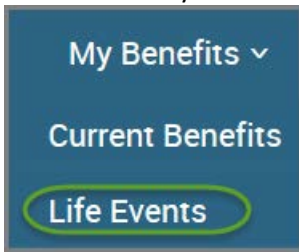
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Removing a Dependent from ALL Benefits

- Hover your cursor over the **“My Benefits”** tab at the top of the screen and choose **“Life Events.”**



- Select **“Other life events...”**

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select **“Child No Longer Eligible.”**


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the effective date (**last day of the month in which coverage is ending**).

STEP 2 Enter your life event information

Child No Longer Eligible [Change life event](#)

When did your life event take place?

Enter a date:

- Check the box next to the dependent’s name.
- Click **“Continue.”**

Update	Name	SSN	Relationship	Date of Birth	Age	Gender	Additional Information
	Joe Test		Employee	1/1/1980	36	M	
	Spouse Test		Spouse	1/1/1980	36	F	Divorced
<input checked="" type="checkbox"/>	Michael Test		Son	1/1/1989	27	M	

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information


Child No Longer Eligible [Change life event](#)

Life Event: **Child No Longer Eligible**
 Date of Event: **08/31/2016**
 Removed from Family: **Michael Test**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue


- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

<p>John Test</p> <p>Male Employee</p> <p>37 years old (1/1/1980)</p> <p>SSN: <input type="text"/></p> <p style="text-align: right;">Edit ></p>	<p>Sally Test</p> <p>Female Spouse</p> <p>37 years old (1/1/1980)</p> <p>SSN: <input type="text"/></p> <p style="text-align: right;">Edit ></p>	<p>Baby Test</p> <p>Female Daughter</p> <p>0 years old (6/15/2017)</p> <p style="text-align: right;">Edit ></p>	<p>Johnny Test</p> <p>Male Son</p> <p>2 years old (1/1/2015)</p> <p>SSN: <input type="text"/></p> <p style="text-align: right;">Edit ></p>
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Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

1 Your info

Employee Information

Family info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info
 Employee Information
 Family Info
Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 ▼

Your Cost per month

PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE

Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Uncheck the dependent's name and click **"Continue"**.

Who will be covered by this plan?

Susan Test Employee
 Spouse Test Spouse
 Child Test Daughter
 Mark Tester Legal Guardianship
 [+ Add Dependents](#)

[← Back to Benefits](#) [Continue](#)

- Select the benefit plan by clicking **"Select"** or **"Keep Selection"**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)
[Plan Brochure](#)

Your Cost per month:
\$25.00
 Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **"Continue"** on the right-hand side.

1 Your Info
 2 **Your Benefits**
 3 Enroll
 4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries](#) (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Your Cost per month **\$50.00**

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage

Coverage Level

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

- 1 Your Info
- 2 Your Benefits
- 3
- Enroll
 - Beneficiaries
 - Other Coverages
- 4
- Complete

Complete Enrollment

Medical

Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Your Cost **\$0.00**

Who will be covered on this plan:

Name	Relationship	Coverage
Test User	Employee	Cover
Spouse User	Spouse	Cover

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3
- Enroll
 - Beneficiaries
 - Other Coverages
- 4
- Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

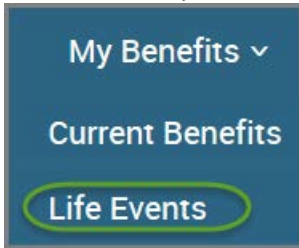
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Removing a Dependent from PARTIAL Benefits

- Hover your cursor over the “My Benefits” tab at the top of the screen and choose “Life Events.”



- Select “Other life events...”

Life Events

 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... ▾

- Select “Family Status Change - Other.”

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... ▾
Divorce
Legal Guardianship
Child Becomes Eligible
Child No Longer Eligible
Family Status Change - Other

- Enter the effective date (enter the last day of the month in which coverage is ending).

STEP 2 Enter your life event information

Family Status Change - Other [Change life event](#)

When did your life event take place?

Enter a date: (mm/dd/yyyy)

Check the **“I verify that all of the above Life Event information is correct.”** box.

- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Family Status Change - Other Change life event


Life Event: **Family Status Change - Other**
Date of Event: 11/01/2016

I verify that all of the above Life Event information is correct.

Hide Event from Employee

Save and Start Life Event Enrollment Cancel

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

OK

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

1

2

3

4

Your Info

Employee Information

Family Info

Questions

Your Benefits

Enroll

Complete

Continue

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Baby Test

Female Daughter

0 years old (5/15/2017)

[Edit >](#)

Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

[Edit >](#)

+

Add Dependents

1 Your Info

Employee Information

Family info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 ▼

Your Cost per month

PLAN MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Uncheck the dependent's name and click **“Continue”**.

Who will be covered by this plan?

Susan Test
Employee
 Spouse Test
Spouse
 Child Test
Daughter
 Mark Tester
Legal Guardianship
 [+ Add Dependents](#)

[← Back to Benefits](#)
[Continue](#)

- Select the benefit plan by clicking **“Select”** or **“Keep Selection”**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)
[Plan Brochure](#)

Your Cost per month:
\$25.00
 Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

- 1 Your Info
- 2 **Your Benefits**
- 3 Enroll
- 4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries \(optional\)](#)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Your Cost per month \$50.00

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

- 1 Your Info
- 2 Your Benefits
- 3
- Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Complete Enrollment

♥ **Medical**
Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:

Name	Relationship	Coverage i
Test User	Employee	✔ Cover
Spouse User	Spouse	✔ Cover

Your Cost **\$0.00**

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3
- Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

✔

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

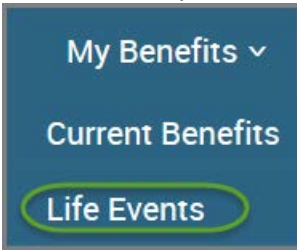
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Adding a Spouse

- Hover your cursor over the **“My Benefits”** tab at the top of the screen and choose **“Life Events.”**



- Select **“Other life events...”**

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select **“Family Status Change - Other.”**


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the effective date (**first day of the month**).

STEP 2 Enter your life event information

Family Status Change - Other [Change life event](#)

When did your life event take place?

Enter a date: (mm/dd/yyyy)

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information


Family Status Change - Other [Change life event](#)

Life Event: **Family Status Change - Other**
Date of Event: **11/01/2016**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “I agree” box.
- Click “Continue”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- To add your spouse, click **“Add Dependents”** and complete the spouse’s demographic information and click **“Save & Continue”**.



Dependent Demographic

* First Name

Middle Initial

* Last Name

Suffix

* Date of Birth

* Social Security Number

* Gender Male Female

* Relationship

* Fields are required

Cancel

+ Save & Add Another

Save & Continue

- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Baby Test

Female Daughter

0 years old (6/15/2017)

[Edit >](#)


Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

[Edit >](#)



Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

- 1 Your Info
 - Employee Information
 - Family Info
 - Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of each plan name.

Medical

\$35.00 v

Your Cost per month

PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE

Employee + Family

Gabriel Test	Employee	✔ Cover
Paige Test	Spouse	✔ Cover
Jason Test	Son	✔ Cover

✔ Completed

View Plan Options

- Check the spouse's name and click **"Continue"**.

Who will be covered by this plan?

Susan Test
Employee

Spouse Test
Spouse

Child Test
Daughter

Mark Tester
Legal Guardianship

[+ Add Dependents](#)

[← Back to Benefits](#)

[Continue](#)

- Select the benefit plan by clicking **"Select"** or **"Keep Selection"**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)

[Plan Brochure](#)

Your Cost per month:
\$25.00

Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **"Continue"** on the right-hand side.

1 Your Info

2 **Your Benefits**

3 Enroll

4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries \(optional\)](#)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Your Cost per month \$50.00

Continue

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

- 1 Your Info
- 2 Your Benefits
- 3 **Enroll**
- 4 Complete

Complete Enrollment

Medical
Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Your Cost **\$0.00**

Who will be covered on this plan:		
Name	Relationship	Coverage
Test User	Employee	Cover
Spouse User	Spouse	Cover

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 **Enroll**
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

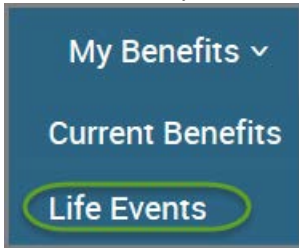
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Removing a Spouse

- Hover your cursor over the **“My Benefits”** tab at the top of the screen and choose **“Life Events.”**



- Select **“Other life events...”**

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select **“Family Status Change - Other.”**


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the effective date (enter the last day of the month in which coverage is ending).

STEP 2 Enter your life event information

Family Status Change - Other [Change life event](#)

When did your life event take place?

Enter a date:

- Check the “I verify that all of the above Life Event information is correct.” box.
- Click “Save and Start Life Event Enrollment.”

STEP 3 Confirm your information

Family Status Change - Other [Change life event](#)


Life Event: **Family Status Change - Other**
Date of Event: **11/01/2016**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

[Save and Start Life Event Enrollment](#)

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click “OK.”

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State ▼

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)

Baby Test

Female Daughter

0 years old (6/15/2017)

[Edit >](#)

Johnny Test

Male Son

2 years old (1/1/2015)

SSN: [REDACTED]

[Edit >](#)

+

Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Uncheck the spouse's name and click **"Continue"**.

Who will be covered by this plan?

Susan Test Employee Spouse Test Spouse Child Test Daughter [+ Add Dependents](#)

[← Back to Benefits](#) [Continue](#)

- Select the benefit plan by clicking **"Select"** or **"Keep Selection"**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan High Deductible

Selected

[View plan details](#)
[Plan Brochure](#)

Your Cost per month: **\$25.00**

Tier: Employee + Dependent

[Keep Selection](#)

- When finished going through every benefit plan, click **"Continue"** on the right-hand side.

1 Your Info
2 **Your Benefits**
3 Enroll
4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries](#) (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Your Cost per month **\$50.00**

[Continue](#)

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage

Coverage Level

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

Medical
Your cost per month **\$0.00**

⚠ This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:

Name	Relationship	Coverage
Test User	Employee	✔ Cover
Spouse User	Spouse	✔ Cover

Your Cost **\$0.00**

- 1 Your Info
- 2 Your Benefits
- 3 **Enroll**
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 **Enroll**
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

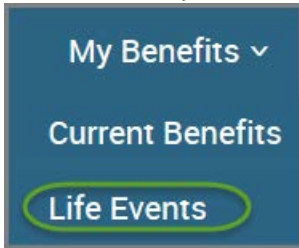
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Adding Medical

- Hover your cursor over the “My Benefits” tab at the top of the screen and choose “Life Events.”



- Select “Other life events...”

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select “Family Status Change - Other.”


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the effective date (first of the month).

STEP 2 Enter your life event information

Family Status Change - Other [Change life event](#)

When did your life event take place?

Enter a date:

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Family Status Change - Other [Change life event](#)


Life Event: **Family Status Change - Other**
Date of Event: **11/01/2016**

I verify that all of the above Life Event information is correct.

Hide Event from Employee

Save and Start Life Event Enrollment

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN:

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN:

[Edit >](#)

Baby Test

Female Daughter

0 years old (5/15/2017)

[Edit >](#)

Johnny Test

Male Son

2 years old (1/1/2015)

SSN:

[Edit >](#)

+

Add Dependents

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

1 Your info

- Employee Information
- Family Info
- Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle that have medical and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “View Plan Options” to the right of the medical plan name.

Medical

\$0.00 ▼

Your Cost per month

PLAN Waive Medical Coverage / WAIVE MEDICAL

COVERAGE

Daniel Test	Employee	✔ Cover
Susan Test	Spouse	✘ No Coverage
John Test	Son	✘ No Coverage

* Selection Required



Keep My Selection

View Plan Options

- To cover a dependent, check the box next to their name.
- To remove a dependent, uncheck the box next to their name.
- Click **“Continue”**.

Who will be covered by this plan?

Gabriel Test Employee
 Paige Test Spouse
 Jason Test Son
 [+ Add Dependents](#)

[Back to Benefits](#)
Continue

- Select the medical plan by clicking **“Select”**.

MESSA ABC Plan 1
Blue Cross Blue Shield of Michigan

[View plan details](#)
[Plan Brochure](#)

Your Cost per month:
\$50.00

Tier: Employee + Family

Select

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

- 1 Your Info
- 2 **Your Benefits**
- 3 Enroll
- 4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

Continue

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries](#) (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

4 Complete

Your Cost per month \$50.00

Continue

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance ▼

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage ▼

Coverage Level ▼

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost **\$0.00**
Per Month

Medical
Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:			Your Cost
Name	Relationship	Coverage ?	
Test User	Employee	✔ Cover	\$0.00
Spouse User	Spouse	✔ Cover	

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

✔ **I agree, and I'm finished with my enrollment**

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
- Beneficiaries
- Other Coverages
- Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

✔

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

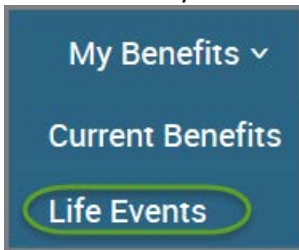
EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.


Removing Medical

- Hover your cursor over the **“My Benefits”** tab at the top of the screen and choose **“Life Events.”**



- Select **“Other life events...”**

Life Events


 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

- Select **“Family Status Change - Other.”**


Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth

> Marriage

Other life events... 

Divorce

Legal Guardianship

Child Becomes Eligible

Child No Longer Eligible

Family Status Change - Other

- Enter the effective date (last day of the month in which coverage is ending).

STEP 2 Enter your life event information

Family Status Change - Other [Change life event](#)

When did your life event take place?

- Check the **“I verify that all of the above Life Event information is correct.”** box.
- Click **“Save and Start Life Event Enrollment.”**

STEP 3 Confirm your information

Family Status Change - Other [Change life event](#)


Life Event: Family Status Change - Other
Date of Event: 11/01/2016

I verify that all of the above Life Event information is correct.

Hide Event from Employee

[Save and Start Life Event Enrollment](#)

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click **“OK.”**

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the “**I agree**” box.
- Click “**Continue**”.

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

By checking the box “I Agree” below, you agree that the information above is accurate to the best of your knowledge.

I agree

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Review/add/edit your Family Information.
- When finished with your Family Information, click the “I agree” box.
- Click “Continue”.

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-888-4167.

John Test

Male Employee

37 years old (1/1/1980)

SSN:

[Edit >](#)

Sally Test

Female Spouse

37 years old (1/1/1980)

SSN:

[Edit >](#)

Baby Test

Female Daughter

0 years old (6/15/2017)

[Edit >](#)


Johnny Test

Male Son

2 years old (1/1/2015)

SSN:

[Edit >](#)



[Add Dependents](#)

Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

I agree

- 1 Your Info
 - Employee Information
 - Family Info
 - Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

[Continue](#)

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Select the PAK/Bundle that does not have medical and click “Continue” on the right-hand side of the screen.

*What PAK of Coverage do you want?

PAK A
 Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK B
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D

PAK C
 Medical – MESSA ABC Plan 2
 Dental - Dent 80/80/80/80:1300(1500)
 Vision - VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

PAK D
 Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx
 Dental - Dent 80/80/80/80:1300(1500)
 Vision – VSP 2S
 Negotiated LTD
 PAK Life - \$50,000 PAK Life
 PAK AD&D - \$50,000 PAK AD&D
 Basic Term Life - \$5,000

I want PAK A
 I want PAK B
 I want PAK C
 I want PAK D

* Fields are required

1 Your Info

Employee Information

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

- Click on “I don’t want this benefit (waive)” under the medical plan name.

Medical

\$50.00 ▼

Your Cost per month

PLAN MESSA ABC Plan 1 / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE Employee + Family

Daniel Test	Employee	✔ Cover
Susan Test	Spouse	✔ Cover
John Test	Son	✔ Cover

✔
Completed

I don't want this benefit (waive)

View Plan Options

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

1 Your Info

2 **Your Benefits**

3 Enroll

4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

Continue

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

Save and Finish Later

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text"/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text"/> %

Total: 100%

+ Add New Beneficiary

✓ Add Secondary Beneficiaries (optional)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 **Enroll**

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost \$0.00
Per Month

Medical
Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:			Your Cost
Name	Relationship	Coverage	\$0.00
Test User	Employee	✔ Cover	
Spouse User	Spouse	✔ Cover	

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Spouse or Child Death

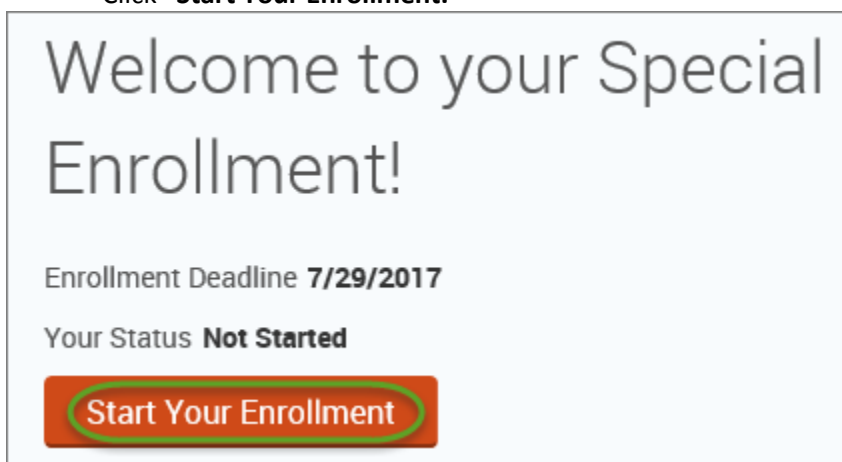
- Please contact your Benefits Administrator to remove a dependent due to death.

ELECTING BENEFITS

If you need to make changes to your benefits due to a qualifying event that is past the eligibility period of 30 days, contact your Benefits Administrator. If your Benefits Administrator approves the qualifying event, they will create a Special Enrollment Event for you.

Once the Event is created by the Benefits Administrator, follow the steps below:

- An enrollment window will display on the home page with the date the enrollment ends.
- Click **“Start Your Enrollment.”**



- Review your demographic information and make any necessary changes.
- Click **"I agree"** and **"Continue."**

Employee Information

Prior to beginning your enrollment, all of your personal and family information must be complete. Please complete the required fields below, or, if the information has already been entered, make sure it is accurate.

Demographics

* First Name

Middle Initial

* Last Name

Suffix

Social Security Number

* Date of Birth

* Gender Male Female

* Fields are required

* Gender Male Female

* Fields are required

Address

Address 1

Address 2

City

State

Zip

* Home Phone

Cell Phone

Home Email

WORK CONTACT INFORMATION

Work Phone

Work Phone Ext.

* Work Email

Preferred Email Home Email Work Email

* Fields are required

- 1 Your Info
 - Employee Info
 - Family Info
 - Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

By checking the box "I Agree" below, you agree that the information above is accurate to the best of your knowledge.

I agree

- Review your family information – make any necessary changes.
 - If the qualifying event includes adding a spouse and/or dependent, click **“Add Dependents”**.
 - Enter the required information for the spouse/dependent.
 - Click **“Save & Continue”**.

Dependent Demographic

* First Name

Middle Initial

* Last Name

Suffix

* Date of Birth

* Social Security Number

* Gender Male Female

* Relationship

* Fields are required

Cancel

- Read the “**Dependent Information Notice**” and click “**I agree.**”
- Click “**Continue.**”

Family Information

To enter your dependents, click on the “+ Add Dependents” link. To verify or edit the information of a family member who has already been entered, click on the person’s name.

Note: If you or any of your family members have a foreign (non-USA issued) SSN, please contact your Benefits Administrator or MESSA Group Services at 888-889-4167.

Mel Tester

Female Employee

36 years old (1/1/1980)

SSN: [REDACTED]

[Edit >](#)


Markese Tester

Male Son

27 years old (8/8/1989)

SSN: [REDACTED]

[Edit >](#)



[Add Dependents](#)


Dependent Information Notice

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday.

NOTE: Your child’s spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstance will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)



1 Your Info

Employee Info

Family Info

Questions

2 Your Benefits

3 Enroll

4 Complete

Continue

Note: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question “What PAK/Bundle of Coverage do you want?”
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click “**Continue**” on the right-hand side of the screen.

Questions

*What PAK of Coverage do you want?

PAK A
Medical – MESSA Choices \$200/\$400
Dental - Dent 80/60/60/60A:1300/1000:2
Vision - VSP 2
Negotiated LTD
PAK Life - \$20,000 PAK Life
PAK AD&D - \$20,000 PAK AD&D
Basic Term Life - \$5,000

PAK B
Dental - Dent 80/80/80/80:1300/1000:2
Vision - VSP 3
Negotiated LTD
PAK Life - \$30,000 PAK Life
PAK AD&D - \$30,000 PAK AD&D

PAK C
Medical – MESSA ABC Plan 1
Dental - Dent 80/80/80/80:1300/1000:2
Vision - VSP 2
Negotiated LTD
PAK Life - \$20,000 PAK Life
PAK AD&D - \$20,000 PAK AD&D
Basic Term Life - \$5,000


I want Pak A.
 I want Pak B.
 I want Pak C.

* Fields are required

- 1 Your Info
Employee Info
Family Info
Questions
- 2 Your Benefits
- 3 Enroll
- 4 Complete

Continue

- Click on “**View Plan Options**” to the right of each plan name.



Medical

NO PLAN SELECTED



*Selection Required

View Plan Options

- To cover a dependent, check the box next to their name.
- To remove a dependent, uncheck the box next to their name.
- Click **“Continue”**.

Who will be covered by this plan?

Gabriel Test Employee
 Paige Test Spouse
 Jason Test Son
 [+ Add Dependents](#)





[Back to Benefits](#)
[Continue](#)

- Select the benefit plan by clicking **“Select”** or **“Keep Selection”**.

CURRENT PLAN

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx

Blue Cross Blue Shield of Michigan  High Deductible

Selected


[View plan details](#)
[Plan Brochure](#)

Your Cost per month: **\$25.00**

Tier: Employee + Dependent

[Keep Selection](#)

- If you wish to waive (remove) a benefit plan, click **“I don’t want this benefit (waive).”**

 **Medical** \$50.00
Your Cost per month

PLAN MESSA ABC Plan 1 / Blue Cross Blue Shield of Michigan / [View plan details](#)

COVERAGE Employee + Family

Daniel Test	Employee	<input checked="" type="checkbox"/> Cover
Susan Test	Spouse	<input checked="" type="checkbox"/> Cover
John Test	Son	<input checked="" type="checkbox"/> Cover

Completed

[I don't want this benefit \(waive\)](#)
[View Plan Options](#)

- When finished going through every benefit plan, click **“Continue”** on the right-hand side.

- 1 Your Info
- 2 **Your Benefits**
- 3 Enroll
- 4 Complete

Your Cost per month **\$50.00**

Finished selecting benefits? Click the button below to continue.

[Continue](#)

Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.

[Save and Finish Later](#)

- You will be required to designate at least one primary beneficiary information when you have life insurance.

- Dependents will automatically appear for you to designate, however you may also **“Add New Beneficiary”** if you’d like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click **“Continue.”**

Please verify your beneficiary information is complete and accurate before proceeding.
 "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.

Basic Term Life

Please choose your beneficiaries

Primary Beneficiaries (required)

Name	Percentage
My Estate (Employee)	<input type="text" value=""/> %
Sally Test (Spouse)	<input type="text" value="100"/> %
Johnny Test (Son)	<input type="text" value=""/> %

Total: 100%

[+ Add New Beneficiary](#)

[v Add Secondary Beneficiaries \(optional\)](#)
 Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month \$50.00

Continue

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click **“Yes”** next to **“Current or Prior Coverages”** and enter the following information.
- Once you have entered the information, click **“Save.”**

Medical

John Test (Employee)

Other Medical Insurance Coverage:

Current or Prior Coverages Yes No

Other Insurance

Policyholder Name

Policy Number

Policyholder's Employer

Policyholder's Employer Address

Policyholder's Employer Phone

Insurance Carrier's Name

Insurance Carrier's Phone

Coverage Start Date

Coverage End Date

State/Country of Coverage

Coverage Level

Additional Info

Save

- If you do not have other medical coverage, keep **“Current or Prior Coverages”** as **“No”** and click **“Continue”**.

1 Your Info

2 Your Benefits

3 Enroll

Beneficiaries

Other Coverages

Review and Confirm

4 Complete

Your Cost per month **\$50.00**

Continue

- Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

Please Review All of Your Selections

Once you have completed your review, click the "Complete Enrollment" button at right side of the page

*Indicates changed benefits

Your Total Cost
\$0.00
Per Month

Medical

Your cost per month **\$0.00**

This benefit election is pending until approved by your Benefits Administrator

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan

COST DETAILS PER MONTH

Who will be covered on this plan:

Your Cost **\$0.00**

Name	Relationship	Coverage
Test User	Employee	Cover
Spouse User	Spouse	Cover

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:

Participation

I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.

I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.

I agree, and I'm finished with my enrollment

- 1 Your Info
- 2 Your Benefits
- 3 Enroll
 - Beneficiaries
 - Other Coverages
 - Review and Confirm
- 4 Complete

Complete Enrollment

- A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!

You may make changes to your elections until: **September 1, 2017**

Please view your enrollment confirmation statement and verify that your selections are correct.

Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.

Your Confirmation Statement is ready

Your Confirmation Statement is an overview of your new benefits and costs for your review and records.

VIEW

EMAIL

PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

129

Revised 01/11/2018

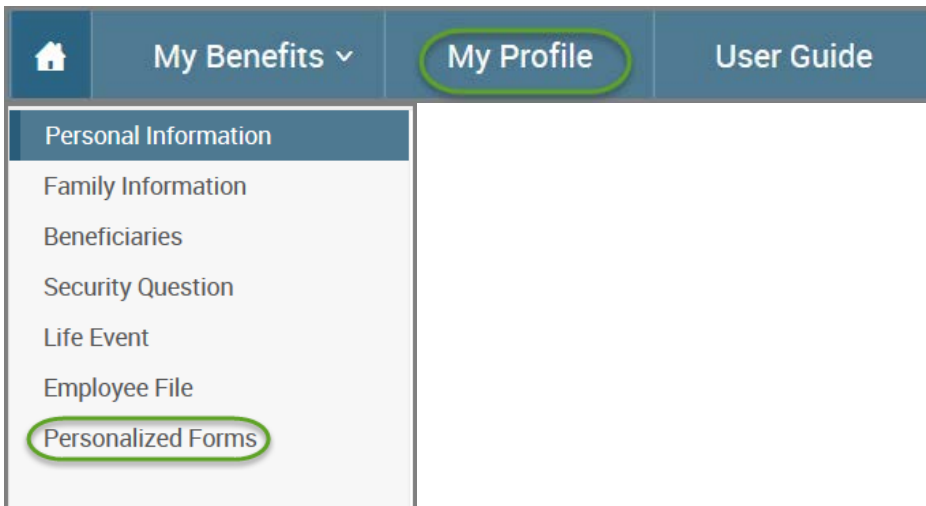
CANCELLING MESSA BENEFITS

If you would like to cancel all MESSA benefits, please see your benefits administrator.

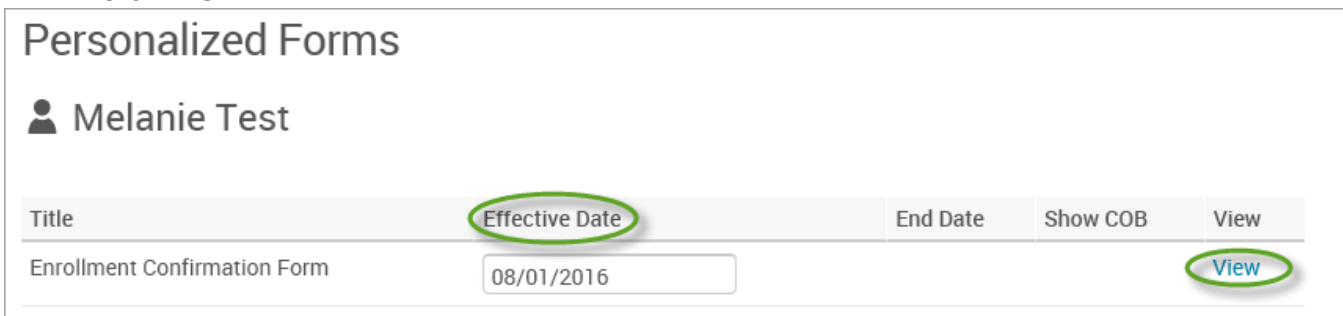
CONFIRMATION STATEMENTS

You have the ability to view/print a confirmation statement for any given effective date at any time.

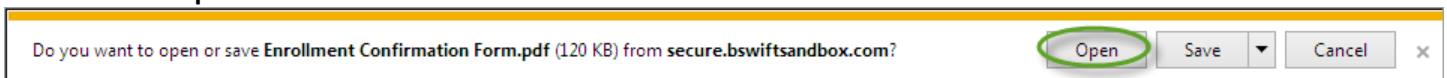
- Click on **“My Profile”** to see your demographic (personal) information.
- Select **“Personalized Forms.”**



- Enter the effective date of the confirmation statement you are requesting.
- Click **“View.”**



- You will get a pop-up that asks you if you want to open or save the confirmation statement.
- Click **“Open.”**



- Your confirmation statement will open for you to view and/or print.



New Elections, Confirmation Statement for Melanie Test

We are pleased to provide you with this personalized summary of your benefit enrollment elections and payroll deductions. For more information about your benefits, please log into www.messa.org and click on My Benefits. If you have any questions, call MESSA at 800.336.0013.

Your Benefits as of 8/1/2016

TOTAL COSTS PER MONTH

Your Cost **\$0.00**

Medical

Your cost per month **\$0.00**

MESSA Choices \$200/\$400

Coverage: **Employee + Family**

Cost Details Per Month

Your Cost **\$0.00**

Who will be covered on this plan:

Name	Relationship	Coverage ⓘ
Melanie Test	Employee	✔ Covered
Spouse Test	Spouse	✘ Waived
Baby Test	Daughter	✘ NOT COVERED

Vision

Your cost per month **\$0.00**

VSP 2

Coverage: **Employee + Dependent**

Cost Details Per Month

Your Cost **\$0.00**

Who will be covered on this plan:

Name	Relationship	Coverage ⓘ
Melanie Test	Employee	✔ Covered
Spouse Test	Spouse	✔ Covered
Baby Test	Daughter	✘ NOT COVERED

Basic Term Life

Your cost per month **\$0.00**

Basic Term Life with Medical

Coverage: **\$5,000.00**

Cost Details Per Month

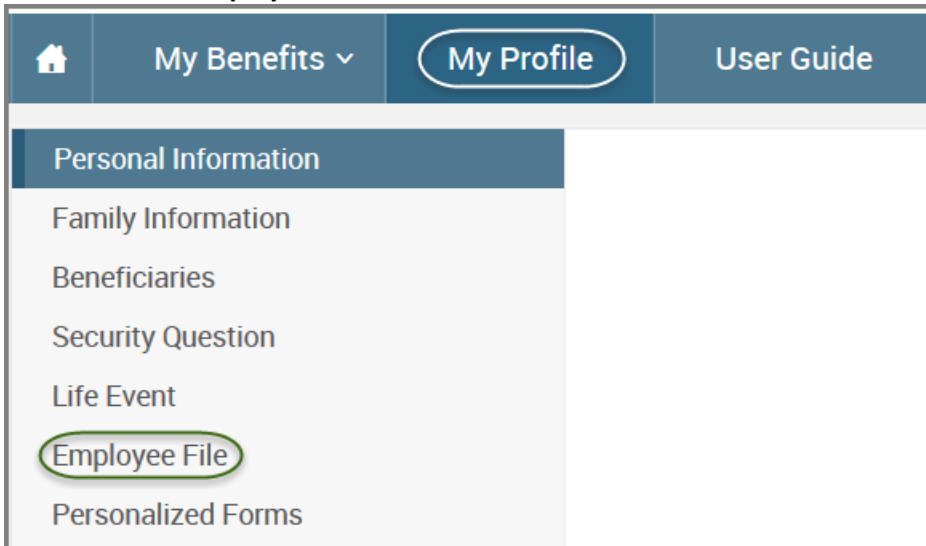
Your Cost **\$0.00**

EMPLOYEE FILE DOCUMENTS

You have the ability to upload documents to MESSA's online benefits website (birth certificate, marriage license, etc.). These documents will be viewable to you and your employer.

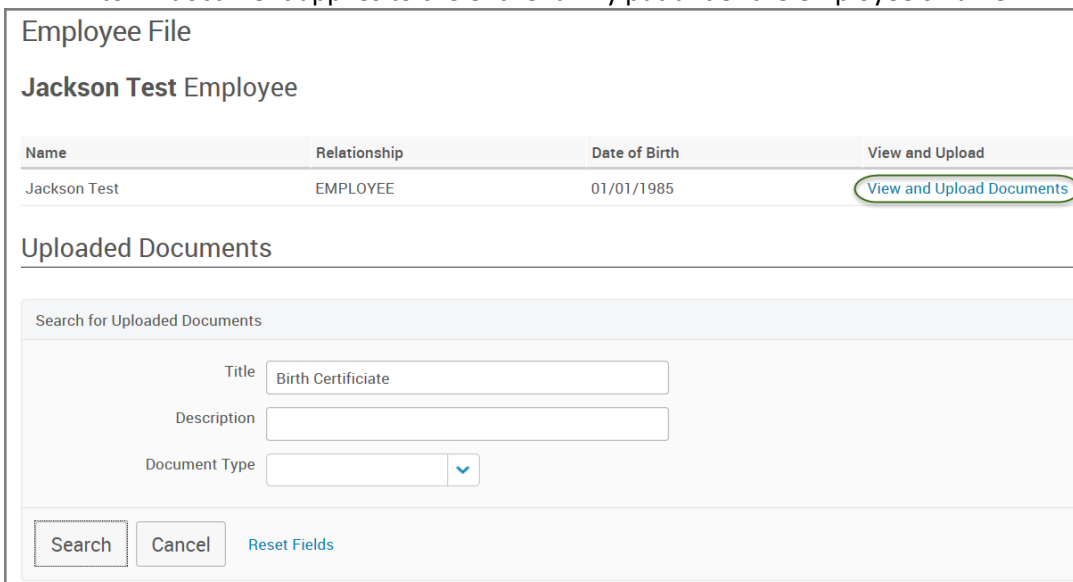
UPLOADING DOCUMENTS

- From your home page, click on **"My Profile"** to see your demographic (personal) information.
- Select **"Employee File."**



The screenshot shows a navigation menu with a dark blue header. The header contains a home icon, 'My Benefits' with a dropdown arrow, 'My Profile' (highlighted with a white oval), and 'User Guide'. Below the header is a list of menu items: 'Personal Information', 'Family Information', 'Beneficiaries', 'Security Question', 'Life Event', 'Employee File' (highlighted with a green oval), and 'Personalized Forms'.

- Click on **"View and Upload Documents"** next to the name of the person that the uploaded documents pertain to. If document applies to the entire family put under the employee's name.



The screenshot shows the 'Employee File' page for 'Jackson Test Employee'. It features a table with the following data:

Name	Relationship	Date of Birth	View and Upload
Jackson Test	EMPLOYEE	01/01/1985	View and Upload Documents

Below the table is a section titled 'Uploaded Documents' with a search form. The search form includes a search bar, a 'Title' field with 'Birth Certificate' entered, a 'Description' field, and a 'Document Type' dropdown menu. At the bottom of the search form are buttons for 'Search', 'Cancel', and 'Reset Fields'.

- Enter the title of your document.
- Enter the Document Type.
- Click **“Browse”** and search for your document on your computer.
- Click **“Save”**.

File Upload

Wife Test Spouse

* Title

Description

* Document Type

* File

* Fields are required

VIEWING UPLOADED DOCUMENTS

- From your home page, click on **“My Profile”** to see your demographic (personal) information.
- Select **“Employee File.”**


My Benefits ▾
My Profile
Library ▾
User Guide

Personal Information

Family Information

Beneficiaries

Security Question

Life Event

Employee File

Personalized Forms

- Documents that have been uploaded will show at the bottom of the screen. To view them click on the link on the right side of the document.

File Upload

Wife Test Spouse

* Title

Description

* Document Type

* File

* Fields are required

10 items per page 1 to 1 of 1 rows

Title	Description	Document Type	Saved On	Saved By	View
<input type="checkbox"/> Birth Certificate		Unspecified	8/15/2017 7:46:08 AM	MESSA Trainers	View

QUESTIONS

If you have any questions, are having trouble logging into the website or you cannot reset your password, please contact your MESSA Member Services at 800.336.0013.