

Enrollment Website

Open then **enrollment instructions** and the link to access your **enrollment site**

How to Start Your Application



Click **here** to view enrollment instructions

Click **here** to enroll

Need Assistance? (877) 286-2852 or LTCiBenefitsTeam@ltc-solutions.com

Enrollment Website

Profile = Setting up your Account
Enter personal information
Set up your employee ID (SSN without dashes)
PIN (you determine)

To create your profile click
“First Time User? Click Here”

After you have set up your profile
At anytime in the future, you need to revisit
your profile or application you can do that by
entering your
employee ID (SSN) and PIN.



benYsel

Welcome

Please select the [First Time User](#) link below to enter your information and begin your enrollment.
If you have any questions, please contact LTC Solutions at (877) 286-2852 or LTCBenefitsTeam@lhc-solutions.com.

If you need to login again after you complete the registration, your Social Security Number will be used as the Employee Number below. The PIN, or password, is the PIN you created when you registered.

You will not need to access the Administrative Site.

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

[FORGOT PIN?](#)

[Login](#)

[First-time user? Click here](#)

Enrollment Website



Enter your
personal information
contact information
employment information
PIN (you determine)

Click Next

New Employee

Personal Info

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

SSN:

First Name

Middle
Initial

Last Name

Date of Birth:

Gender: ☐ Male ☐ Female ☐ Other

Contact Info

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

Address:

Country

Street Address Line 1

Street Address Line 2

City

State

ZIP

Enrollment Website

You will be brought to the
Welcome Screen

Click **Next**

 **Status** (0% Complete)

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

Welcome to Your Benefit Enrollment for Plan Year 2021-2022

At TEST - Shared URL by Broker, we know that benefit requirements change. That's why we are offering a new Universal Life plan with Accelerated Death Benefit for Long Term Care.

For this benefit, Initial Enrollment is the only time of year you can take advantage of the Guaranteed Issue offer.

New Group Universal Life Insurance Long Term Care Benefits for 2021

When you elect Group Universal Life Insurance coverage from Allstate Benefits, the following Long Term Care benefit riders are automatically included if you are 18-70 years of age.

Accelerated Death Benefit for Long Term Care Rider

This rider can provide an advance of the life insurance benefit as monthly cash payments when an insured person receives qualified long-term care services. The insured must be certified by a physician as chronically ill. Chronically ill means you have lost the ability to perform two (2) or more activities of daily living (bathing, continence, dressing, eating, toileting or transferring) or are severely cognitively impaired. Monthly premium payments are not charged while the insured is receiving benefit payments under this rider. The monthly Long Term Care benefit is equal to 4% of the life insurance benefit after a 90-day elimination period and is subject to the pre-existing condition exclusion.

Benefits are not paid for long-term care services that are a result of mental or emotional disorder (except for Alzheimer's Disease, senility or senile dementia that are of organic origin); a result of alcoholism or drug addiction; a result of illness, treatment or medical conditions due to act of war, declared or undeclared, service in the armed forces or units auxiliary thereto; participation in a felony, riot or insurrection, suicide or attempt at suicide, or intentionally self-inflicted injury provided in a government facility (unless required by law); services for which benefits are available under Medicare (except for deductibles or co-insurance requirements); or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law; or motor vehicle no-fault law; received outside the United States or its territories.

Group Universal Life Insurance benefits are provided under policy and rider forms GUL239, GUL2C2 or state variations thereof.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits representative.

Benefit enrollment is easy! Just follow these steps.

- First, review and contact HR to update personal information about you or your covered dependents.
- Review each of your benefit elections and make your choices.
- Sign the Enrollment Confirmation form to complete your enrollment.

Click [Next](#) to begin.

Press [Next](#) to review personal information and begin enrollment.

[Next](#)

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Enrollment Website

Confirm
personal information
contact information
is correct.

Click Next when finished

Personal Info

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

Employee ID:

SSN:

First Name

Middle
Initial

Last Name

Date of Birth:

Gender:

☐

Male

☐

Female

☐

Other

Contact Info

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

Address:

Country

Street Address Line 1

Street Address Line 2

Enrollment Website

Click **Add**
to add your spouse/Domestic
Partner.

Click **Next** when finished

The screenshot shows the 'Dependents' page of an enrollment website. At the top is a navigation bar with links: Home, You & Your Family, My Benefits, and Sign & Submit. On the right of the navigation bar are 'Back' and 'Next' buttons. Below the navigation bar is the 'Dependents' section. It contains a light blue informational box with a plus icon and text: 'Click Add ("Plus" icon at top right of table) to add your spouse or dependent children. Dependent children may only be covered in a plan if they meet the necessary requirements defined by the plan. Click the Next button when you are finished.' Below this is a table with the header 'Dependents' and the text 'No Dependent Information Available'. The table has columns: Name, SSN, DOB, Sex, Relation, and Uploads. The bottom of the table shows 'No items found.' and a plus icon in the rightmost cell. Below the table is the 'Add a Dependent' section, which includes the text: 'If your dependent is not listed above or you would like to add an additional dependent, simply click the Add Dependent button below.' and a blue button with a plus icon and the text 'Add Dependent'. At the bottom of the page are 'Back' and 'Next' buttons. A large orange arrow points from the 'Add' text in the instructions to the plus icon in the table header. Another large orange arrow points from the 'Next' button in the bottom right to the 'Next' button in the bottom right.

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

Dependents

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

Dependents

No Dependent Information Available

Name	SSN	DOB	Sex	Relation	Uploads	+
No items found.						

Add a Dependent

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

+ Add Dependent

Back Next

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Enrollment Website

Confirm
employment information
is correct

Click **Next** when finished

Employment

i Please review and correct your employment information shown here. Optional items are shown in *italics*.

Certain items require additional information from you. These items are highlighted and underlined. Click on the item to correct it, if necessary.

Press **Next** to continue.

Employment Info

Date of Hire: 1/1/2012

Eligibility Date: 1/1/2012

Location: Headquarters

Department: Default

Job Class: FT

Title:

Salary: \$0.00

Pay group: Monthly

Payroll Frequency: Monthly

Hours per Week: 40.00

Back

Next



Enrollment Website

Plan and Rates section

Select tobacco status
Scroll down to view rates

GWL with LTC



Life Insurance

A death not only leaves behind loved ones, but may also leave significant financial obligations.

Life insurance from Allstate Benefits provides a lump-sum cash benefit upon death. Plus, life-event riders can be added to enhance the life coverage. Life insurance coverage is for the living; those left behind must deal with final expenses, bills, mortgage, and expenses associated with day-to-day life. It can also help provide financial security during life-changing events that occur as the insured ages and financial needs change.

[Instructions](#)[Informational Video](#)[Key Features](#)

Select the desired amount of Group Life Insurance or cost from the list below. You may select any optional coverages (if offered) from the list below.

To apply, select *I wish to apply for this coverage*. If you do not wish to purchase this coverage, choose *I wish to DECLINE this coverage*. Press *Next* when you are finished.

Allstate Benefits (AB) is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

ABJ4542WA

Insurance for TEST TEST

Has the employee used tobacco in the last 12 months?

Monthly Cost: \$0.00

My Benefits

● GWL with LTC \$0.00

 **Total Cost**
Per Month **\$0⁰⁰**

Enrollment Website

Select
Plan design amount
OR
Premium cost

To apply
Select I wish to apply for this coverage

To decline
Select I wish to DECLINE this coverage.

Click **Next** when finished

Monthly Cost	Benefit Amount
☐ \$5.67	10,000
☐ \$11.35	20,000
☐ \$17.02	30,000
☒ \$22.70	40,000
☐ \$28.37	50,000
☐ \$34.05	60,000
☐ \$39.72	70,000
☐ \$45.40	80,000
☐ \$51.07	90,000
☐ \$56.75	100,000

Application riders

- ☒ Accelerated Death Benefit for Terminal Illness or Condition
- ☒ Accelerated Death Benefit for Long Term Care

Total Premium: \$22.70

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

Back

Next



Enrollment Website

Choose Beneficiaries

Place a checkmark next to each desired primary and contingent beneficiary.

The percentage allocations will automatically calculate.

Click Add if you do not see the desired person in the list.

You may change the percentages, and they must add up to 100%.

Click Next when finished

GWL with LTC

Choose Beneficiaries

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

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

Beneficiary	Relationship	Primary	Contingent	
All Living Children		☐ 0.00%	☐ 0.00%	/ ✕
Estate		☐ 0.00%	☐ 0.00%	/ ✕

Back

Next

ADD

Next

Enrollment Website

Answer Questionnaire

Click **Next** to continue to the next page

Secondary Addressee Designation. Protection against unintended lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. Would you like to designate at least one additional person to receive notification of a possible lapse or termination of coverage? If yes, please provide full name and mailing address.

☐ Yes ☒ No

Is this rider to replace or change any existing accident and health or long term care coverage?

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

Are you covered by Medicaid?

☐ Yes ☒ No

Enrollment Website

Review your benefits section

To make changes **click back**

Click Confirm when finished

GWL with LTC

Enrollment Details

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

Beneficiary Information

Name	Relationship	Address	Phone	Percent	Type
All Living Children				100.00	Primary

Monthly deduction

Cost: \$65.85 (post-tax)

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

Back

Confirm

My Benefits

● GWL with LTC \$0.00

 **Total Cost**
Per Month \$0⁰⁰

Enrollment Website

Enter your bank account information

Premiums will be deducted monthly from this bank account

Click Next when finished

Payment Information

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

Payment Type: Bank Draft

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



① 0000576944
Transit/ABA Number
② 123456789
Account Number
③ FIRST NATIONAL BANK
331 Main St
Boulder, CO 87012-8271
Institution Name/Address

Type of Account: Personal

Checking

Account No.:

Transit/ABA No.:

Account Holder Name: TEST TEST

Bank Draft Day: 1

Depository Name/Branch:

Address:

City:

State:

ZIP:

Back

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

Next

Enrollment Website

Review your enrollment elections
Click Next

To make changes to your election
Click My Benefits
Click GWL with LTC

CHANGES

Home	You & Your Family	My Benefits	Payment Information	Sign & Submit	Next
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Sign and Submit

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

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

Your Benefits

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

Signatures Required

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

Form Name	Status	Date Signed/Reviewed
☒ ABJOGWLTC1WA Outline of Coverage	Not Reviewed	N/A
☒ ABJ21526WA SUMMARY AND DISCLOSURE STATEMENT	Unsigned	
☒ ACH Authorization	Unsigned	
☒ ACH Confirmation	Unsigned	

Next

Review and Sign Forms

Click Sign Form

Review / Sign Forms

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

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

Form Name

- ☒ [ABJ13510 SUMMARY AND DISCLOSURE STATEMENT](#)
- ☒ [AWD13513WA SUMMARY AND DISCLOSURE STATEMENT](#)
- ☒ [ABJOGULTC2WA Outline of Coverage](#)

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

Sign Form

Next

Sign Forms

Enter PIN

Click Sign Form

Enrollment Agreement / Deduction Authorization

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

Your total
monthly
deductions...

Total Deductions

\$ 65.85

Employee Signature

Date

[Download Fo](#)

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

PIN:

Sign Form

Enrollment Website

Sign/Submit Complete

Click ACH Confirmation

Sign/Submit Complete

Congratulations!

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

Recap of Your Elections

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

✓ GWL with LTC

Enrollment Details

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

Beneficiary Information

Name	Relationship	Address	Phone	Percent	Type
All Living Children				100.00	Primary

Completed Forms

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

Form Name	Date Signed/Reviewed
 ABJOGWLTC1WA Outline of Coverage	N/A
 ABJ21526WA SUMMARY AND DISCLOSURE STATEMENT	09/02/2021
 ACH Authorization	09/02/2021
 ACH Confirmation	09/02/2021

Logout

ACH Confirmation

Print for your records

Benefit Verification / ACH Confirmation				
Name TEST TEST	SSN 454545454	Employee ID 0	Date of Hire 01/01/2012	Reason for Completing Form Open Enrollment
Location Headquarters	Department default	Job Class Full Time		Address 14715 NE 95th Street Suite 200 Redmond, WA 98052
Work Phone	Home Phone	E-mail		
Benefit Deduction Summary				
Plan GWL with LTC	Product AB Group Whole Life (GWL)	Cvg EO	Cost 65.85	
		Total	65.85	
Enrollment Agreement / Deduction Authorization				
- To the best of my knowledge and belief, all statements and answers made on this form and all associated application forms are true, complete, and correct. - I understand that omissions or misrepresentations in the information I have provided may constitute fraud and may result in my coverage being void. - If I elect an amount over guaranteed issue maximum, I understand that subject to underwriting review, my coverage may be reduced to the guaranteed issue maximum, if applicable. If my benefit amount is reduced, I understand recurring withdrawals will be reduced accordingly, but will never be more than what I authorize above. - Upon acceptance by the insurers, I hereby authorize the Carrier to deduct from my Bank Account the amounts indicated above. - My authorization shall continue thereafter until written notice from me cancelling this authorization.				
Your total monthly deductions...		Total Deductions		
\$ 65.85				
		[*****] Electronic Signature on File		09/02/2021
		Employee Signature		Date



Questions?

Toll Free: 877.286.2852

Email: LTCiBenefitsTeam@ltc-solutions.com

This provides a brief description of your benefits and is not a contract. Benefits, exclusions and limitations may vary by state, or may be named differently. Please consult your policy for complete information. A complete policy illustration will be delivered with your policy or certificate.