

**Butler Health Plan Instructions for
Online Enrollment at
www.alliedbenefit.com**

November 7- November 18, 2011

- ✓ If you currently have medical and/or dental coverage through the Butler Health Plan, you have to complete the online enrollment. If you are not currently in the medical and/or dental plan, you must see your Treasurer or Personnel Department to enroll.
- ✓ You need to have an Account Number and Password from Allied Benefit Systems. If you do not have this, please follow the instructions on the next page.
- ✓ All changes made online to your medical and/or dental plans will be effective January 1, 2012. **Remember...Open Enrollment is the only time you can make changes without a qualifying event.**
- ✓ To enroll, log in directly to www.alliedbenefit.com. Submit your changes no later than 11p.m. on November 18, 2011. Please review to ensure your information is submitted correctly.

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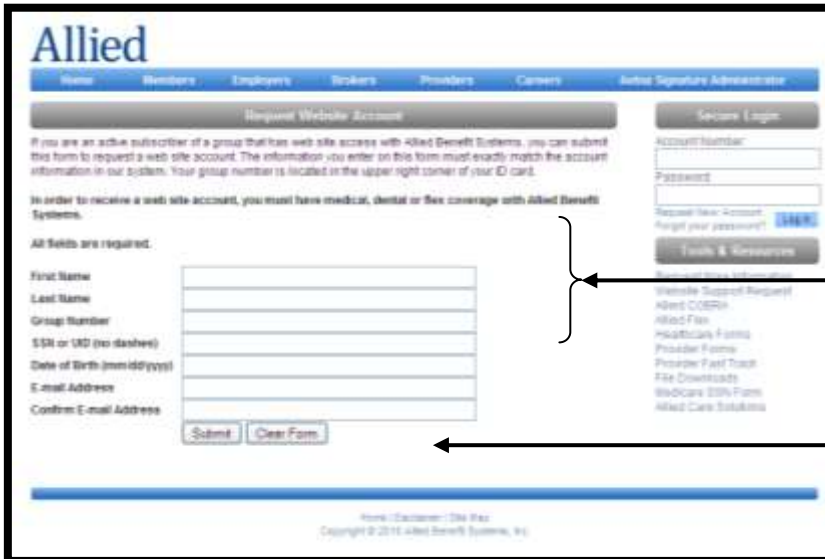
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First Time Using the Allied Website?

Log in to www.alliedbenefit.com. You will be at the home page of Allied Benefits.



Select "Request New Account"



All fields must be completed. Note: The information you enter on this form must exactly match the account information in Allied's system. Your group number is **A08103**, which located in the upper right corner of your ID card.

Press **SUBMIT**

After the form is submitted, you will receive a confirmation email to the email address that you provided. Keep this for your records. This information will be needed to access Allied Benefit System's website.

Forgot Your Account Number or Password?

Log in to www.alliedbenefit.com. You will be at the home page of Allied Benefits.



Click on ***Forgot Your Password***

- Enter the required information.
- Your Account Number and Password will be emailed to you.
- If your email has changed, you must call Allied at 1-800-288-2078 to get your account number and password.

Steps to Enroll

Log in to www.alliedbenefit.com. You will be at the home page of Allied Benefits.

Home Members Employees Brokers Providers Carriers Home Signature Administration

Taking Care of You and Your Family Every Day

Tools & Resources
Regular Rate Information
Website Support Request
Allied Files
Healthcare Forms
Provider Fax Track
File Downloads
Member Self-Service
Allied Case Solutions

Integrate Website Tools For Your Members
Find and Compare Hospitals
Search for hospitals in your area.
Browse by line, services, and types of care.
Compare Drug Treatments
Research and compare drug treatment options for specific medical conditions.
Knowledge Exchange
Learn about medical products and conditions.
Be prepared to discuss your medical history with your healthcare provider.
Health e-Verify
Receive custom wellness notifications alerting you of important medical products and tools.

Secure Login
Account Number:
Password:
Remember account? **Log In**
Forgot your password?

SAS 70

Enter your *Account Number* and *Password*
Press **Log In**

Subscriber

Home Site Map My Account Change Plan Logout

Claims Compliance Decision Maker Eligibility Notifications Online Support Plan Info Reporting

Subscriber Home Page

ALLIED MEMBER SERVICES
Call 312-906-8880 or 800-298-2076 (outside IL) Mon-Thur: 7:30am-7pm, Fri: 8am-5pm, Sat: 9am-12pm Central Time

Open Enrollment is Currently Active - Click Here to Enroll Online

Please read Allied's web site [disclaimer](#) statement for important information related to online eligibility inquiries.

Subscriber Information Current Coverage

Select "**Click Here to Enroll Online**"

Butler 2012 Open Enrollment

Open Enrollment Period: 11/7/2011 to 11/18/2011 Enrollment Last Updated: 9/22/2011 9:43:21 AM

Data Formatting Rules
 Required fields denoted by * and highlighted as: [yellow] Provisionally required fields denoted by **
 Dates: MM/DD/YYYY Phone numbers: NNN-NNN-NNNN Zip codes: NNNNN or NNNNN-NNNN
 Money: NNNN.NN (no \$ symbol or other punctuation except decimal)

Subscriber Plan and Location Selection

Plan* [Select a plan... v] Location* [EDGEWOOD CITY BOARD OF EDUCATION v]
 Effective Date** [Select a plan... v]
 PPO
 HDHP
 DENTAL ONLY

Subscriber Information

First Name* [Charles] Last Name* [Jones] Middle Initial [] Gender* [Female v]
 Date of Birth* [11/16/1961] Soc Sec Num* [] HICN** (if applicable) [] Unique ID** [ZZ0012389]
 Address Line 1* [1234 John Drive] Address Line 2 [] City* [Columbus] State* [Ohio v]
 Zip Code* [45067] Primary Phone** [] Alternate Phone 1** [] Alternate Phone 2** []
 Address Effective Date** [01/01/2012] Marital Status* [Select... v]
 Email Address** [oe68@allied.com] Confirm** [oe68@allied.com]

Subscriber Plan and Location Selection:

The online system will default to "Select a Plan." Select the PPO Plan, HDHP Plan or Dental Only option you elect as of January 1, 2012.

Subscriber Information:

Update any blank field. Highlighted fields are mandatory. Verify the accuracy of your information.

Family Members

First Name*	Last Name*	Date of Birth*	Gender*
MICHELE [123456789]	JONES	12/02/1987 [Spouse v]	Female v
MICHAEL [121654987]	JONES	04/21/1998 [Dependent v]	Male v
SARAH [789456123]	CUNNINGHAM	11/09/1992 [Dependent v]	Female v
EVAN [123854789]	JONES	06/24/1997 [Dependent v]	Male v

Member Benefits

Member Name	Relationship	Available Benefits
CHARLES	Subscriber	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHELE	Spouse	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHAEL	Dependent	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
SARAH	Dependent	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
EVAN	Dependent	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental

Family Members:

Update any blank field. Highlighted fields are mandatory. Verify the accuracy of your information

Member Benefits:

Selections for members will be effective January 1, 2012.

Select Medical and/or Dental for each covered person.

If you uncheck a member's benefit it will terminate that member's benefit effective 1/1/2012.

Add Members: This will allow you to add a new spouse or dependent.

Use this section to add a new family member, once added you can assign benefits to the family member

First Name* [] Last Name* [] Date of Birth* [] Gender* [Select... v]
 Social Sec Num* [] HICN** (if applicable) [] Relationship* [Select... v]
 [Add New Family Member] [Clear]

If you add a dependent to your coverage remember you need to turn in your Proof of Dependent Status information to your District Representative.

Member Benefits

Member Name	Relationship	Available Benefits
CHARLES	Subscriber	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHELE	Spouse	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHAEL	Dependent	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
SARAH	Dependent	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
EVAN	Dependent	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental

I am waiving: Medical Coverage Dental Coverage

Waiving Coverage:

If you are waiving either medical or dental coverage for you or any covered person under the plan, please select "I am waiving medical and dental coverage."

Other Medical Insurance

Member	Other Ins?*	Relationship	Carrier Name**	Carrier Location (city, state, zip)**
ROBERT	<input type="radio"/> Yes <input checked="" type="radio"/> No	Subscriber	<input type="text"/>	<input type="text"/>
TIMMY	<input type="radio"/> Yes <input checked="" type="radio"/> No	Dependent	<input type="text"/>	<input type="text"/>
LISA	<input type="radio"/> Yes <input checked="" type="radio"/> No	Spouse	<input type="text"/>	<input type="text"/>

Spousal Coordination of Benefits

- My spouse has access to the Butler Health Plan through his/her school employer.
- My spouse does not have access to another group health plan.
- My spouse has access to health coverage through another group health insurance plan. This includes retirees with access to an employer sponsored group health plan, or retirement system.

Please print, complete and submit the following document if your spouse has access to health coverage through another group health insurance plan: [COB Questionnaire](#)

Other Medical Insurance: If you or any covered dependent has access to other insurance please provide this information

Spousal COB: You are required to fill out this section if you currently have a spouse on the Plan. If you have no spouse this section will not appear. Please read instructions and be sure you fill out and print the attached document based on your selection.

Earn Credit Toward Your 2012 Medical Plan Deductible! - Tobacco-Free Credit

I, Employee, have not used tobacco of any kind in the last three months.

I, Employee, have used tobacco products and have already enrolled in a Tobacco Cessation Program by contacting Tracey Taylor (513-551-1437).

I, Employee, am a tobacco user and understand I do not qualify for the credit.

My spouse has not used tobacco of any kind in the last three months.

My spouse has used tobacco products and has already enrolled in a Tobacco Cessation Program by contacting Tracey Taylor (513-551-1437).

My spouse is a tobacco user and understands he/she does not qualify for the credit.

Important Notice - Please Read and Check the Confirmation Box(es) Below

E-Signature

Any person who knowingly and with intent to defraud, files a statement containing any materially false information or conceals, for the purpose of misleading information concerning any fact materials thereto, commits fraud which is a crime and could jeopardize your coverage. I hereby consent and authorize any dentist, physician, supplies, hospital, pharmacy, insurance company, employer or organization to disclose any medical information concerning myself or my dependents to the health

I Agree

Tobacco Credit: You are required to fill out this section if you are electing medical benefits.

E-Signature: This section serves as your digital signature that you are certifying that everything you have filled out is correct.

Click here to submit your enrollment: Once you click this button your information will be submitted for enrollment to be effective January 1, 2012. You will see:
Your enrollment was successfully submitted!

Note: If you submit your enrollment and need to make additional changes, repeat the steps above and resubmit. This will override previous changes.

You can now:

- Print a copy of your enrollment for your records
- Edit your enrollment
- Return to the Home Page

Changes will not be accepted after November 18, 2011