



LINCOLN LAND COMMUNITY COLLEGE ONLINE BENEFIT ENROLLMENT

May 1, 2017 – June 8, 2017

What you need to know...

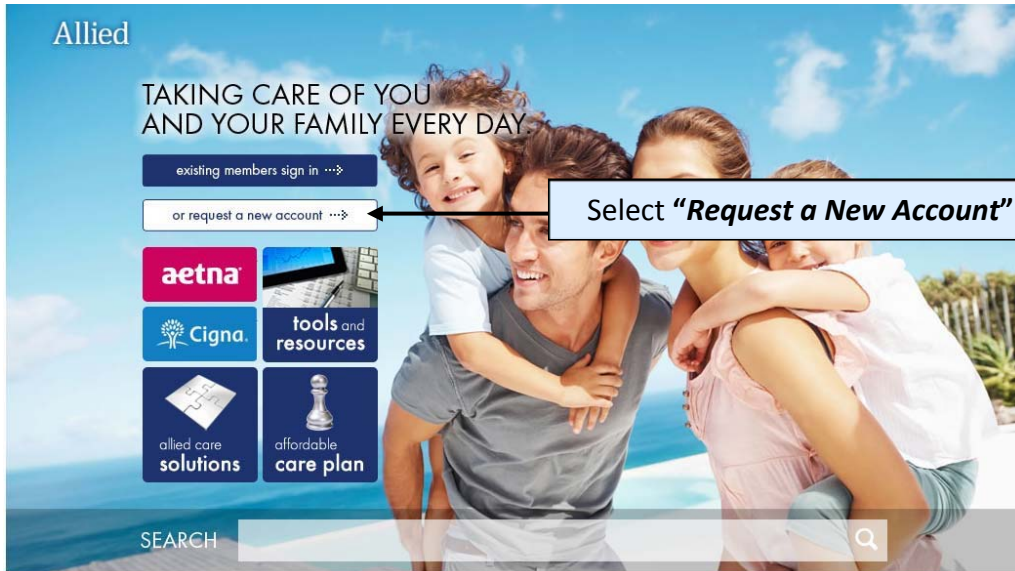
- ✓ Only those employees who are changing plans, adding/dropping dependents, contributing to a flexible spending account and/or declining health insurance coverage must go online and complete enrollment information.
- ✓ Flex Enrollment with Allied is required on an annual basis. **You must complete the online enrollment if you are electing Flex, even if you are only taking LLCC's contribution.**
- ✓ You will need to have an Account Number and Password from Allied. If you do not have an account, please follow the instructions on the next page.
- ✓ All changes made online to your medical, vision and/or dental plans will be effective July 1, 2017. ***Remember...Open Enrollment is the only time you can make changes without a qualifying event.***
- ✓ Use the Medical, Vision and Dental summaries provided to review your benefit options.
- ✓ There is only one way to enroll:
 - Online...through www.alliedbenefit.com. Submit your changes no later than midnight of June 8, 2017. Please review to ensure your information is submitted correctly and PRINT your confirmation page!

Changes will not be accepted after June 8, 2017

ACCESSING LLCC ONLINE BENEFIT ENROLLMENT

I'VE NEVER LOGGED ON TO ALLIED...WHAT DO I DO?

Through your web browser type www.alliedbenefit.com in the address line and press enter. You will be at the home page of Allied Benefits.



request website account

If you are an active subscriber of a group that has website access with Allied, you can submit this form to request a website account. The information you enter on this form must exactly match the account information in our system. Your group number is printed on your ID card.

In order to receive a website account, you must have medical, dental or flex coverage with Allied.

All fields are required.

first name

last name

group number

SSN or UID (no dashes)

date of birth (mm/dd/yyyy)

email

confirm email

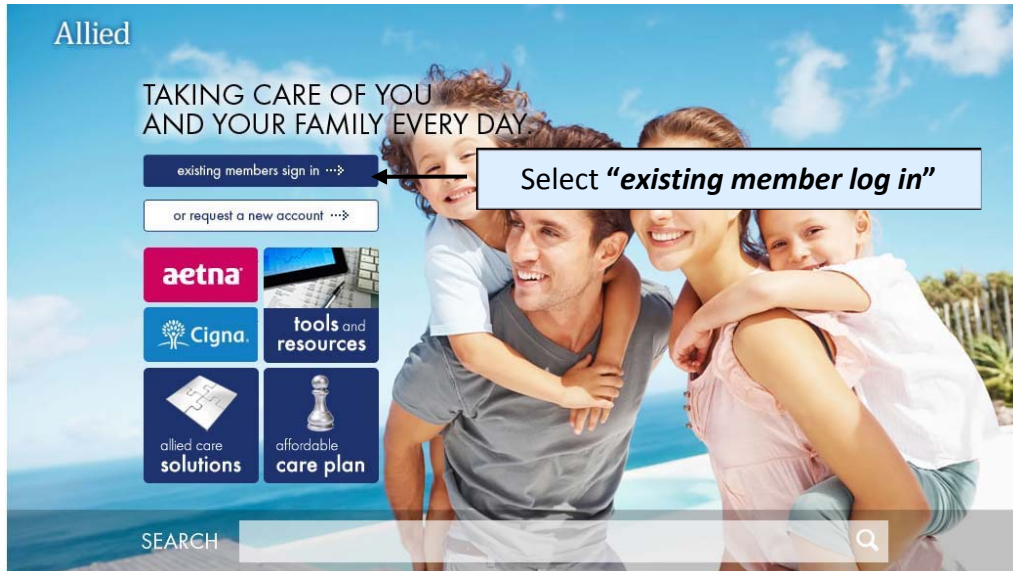
All fields must be completed. Note: The information you enter on this form must exactly match the account information in Allied's system. **Your group number is A12126.**

Press **Submit Request**

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.

I HAVE MY ACCOUNT NUMBER AND PASSWORD...WHAT DO I DO NEXT?

Through your web browser type www.alliedbenefit.com in the address line and press enter. You will be at the home page of Allied Benefits.



sign in

To sign in, enter your account number and password and click on the Submit button to Sign in. Please read the Allied web site [disclaimer and user policy](#). Unauthorized user access is prohibited.

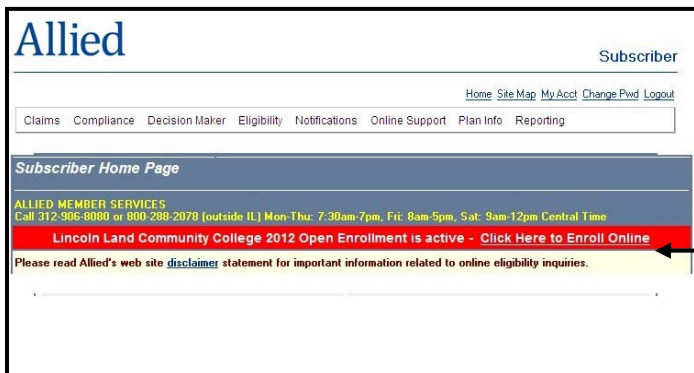
Account Number

Password

[Forgot Your Password?](#) | [Request New Account](#)

[Sign In](#)

Enter your **Account Number** and **Password** and click **Sign In**



Completing Enrollment

Lincoln Land Community College 2012 Open Enrollment

Enrollment Period 4/1/2012 to 5/31/2012 Enrollment Last Updated: 4/25/2012 10:22:34 AM

Subscriber Plan and Location Selection

Plan* **Location***

Effective Date**
on, location and/or benefit changes will begin on the Effective Date

IMPORTANT MESSAGE: HDHP, DENTAL ONLY, or FLEX ONLY benefits will be reset after a new plan is selected

Subscriber Information

First Name* <input type="text" value="ADAM"/>	Last Name* <input type="text" value="SMITH"/>	Middle Initial <input type="text"/>	Gender* <input type="text" value="Male"/>
Date of Birth* <input type="text" value="02/08/1980"/>	Soc Sec Num* <input type="text" value="123456789"/>	HICN** (if applicable) <input type="text"/>	Unique ID** <input type="text"/>
Address Line 1* <input type="text"/>	Address Line 2 <input type="text"/>	City* <input type="text"/>	State* <input type="text" value="Select..."/>
Zip Code* <input type="text"/>	Primary Phone** <input type="text"/>	Alternate Phone 1** <input type="text"/>	Alternate Phone 2** <input type="text"/>
Address Effective Date** <input type="text" value="07/01/2012"/>	Marital Status* <input type="text" value="Select..."/>	Reference Number <input type="text" value="12171"/>	
Email Address** <input type="text"/>		Confirm** <input type="text"/>	

Subscriber Plan and Location Selection:

The online system will require you to select the plan you elect as of July 1, 2017. If you wish to waive health and dental coverage then select FLEX ONLY. If you just want to waive health coverage, select DENTAL ONLY.

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*
Social Sec Num*	Medicare HIC Num**	Relationship*	
<input type="text" value="Bill"/>	<input type="text" value="Johnson"/>	<input type="text" value="06/03/1953"/>	<input type="text" value="Female"/>
<input type="text" value="123456789"/>	<input type="text"/>	<input type="text" value="Spouse"/>	
<input type="text"/>	<input type="text"/>	<input type="text" value="Select.."/>	<input type="text" value="Select.."/>
<input type="text"/>	<input type="text"/>	<input type="text" value="Select.."/>	<input type="text" value="Select.."/>

Family Members:

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

Member Benefits						
Member Name	Relationship	Available Benefits				
ADAM	Subscriber	<input checked="" type="checkbox"/> Medical	<input checked="" type="checkbox"/> Dental	<input checked="" type="checkbox"/> Flex		
MARK	Dependent	<input checked="" type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Flex Debit Card		
I am waiving: <input type="checkbox"/> Medical Coverage <input type="checkbox"/> Dental Coverage						
Flexible Spending Account						
Flex Type	Selected**	Annual Pledge**	Allowable Range		Previous Pledge	
Health Care	<input checked="" type="checkbox"/> Yes	2500	\$0	To \$2500	\$0	
Dependent Care	<input type="checkbox"/> Yes		\$100	To \$2500	\$0	
<input checked="" type="checkbox"/> Enable direct deposit for flex reimbursements (requires flex benefit)						
Subscriber Banking and Direct Deposit Information						
Bank Name**	Chase	Account Type**	Checking	Effective Date	07/01/2012	
Account Number**	123456	Confirm Account Number**	123456			
Routing Number**	987654321	Confirm Routing Number**	987654321			

Member Benefits:

Selections for members will be effective July 1, 2017.

Select Medical, Dental, and/or Flex for each covered person.

Flex:

If you are electing flex check the box of the benefit(s) you want and enter what your pledge is going to be. **

****NOTE**

If you are waiving health insurance coverage and want the LLCC contribution, you must check the Health Care flex box and enter an annual pledge amount that you would like to contribute to the account (not LLCC's contribution) from \$0 to \$1,300. If you contribute any amount in the range of \$0 to \$500, LLCC will contribute \$500 to your account. Employee contributions above \$500 but not exceeding \$1,300 will be matched dollar for dollar by LLCC. The total employee/employer contribution cannot exceed \$2,600 annually per IRS guidelines.

Direct Deposit:

If you want your Flex reimbursements sent via Direct Deposit, select the check box and fill out the banking section.

Other Medical Insurance				
Member	Other Ins?*	Relationship	Carrier Name**	Carrier Location (city, state, zip)**
TAMARA	<input type="radio"/> Yes <input checked="" type="radio"/> No	Subscriber	<input type="text"/>	<input type="text"/>
ADAM	<input type="radio"/> Yes <input checked="" type="radio"/> No	Dependent	<input type="text"/>	<input type="text"/>

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

Important Notice

If you refuse coverage for yourself, you automatically refuse that coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to

I have read the above and certify that the above information is true and accurate

[Click here to submit transaction](#) [Close](#)

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

NOTE: To be eligible to enroll in the High Deductible Plan, you cannot have any other medical insurance or be enrolled in Medicare.

Important Notices: Please read the open enrollment disclaimer, by checking the box you have agreed to the terms and conditions of this enrollment.

- a. Acknowledgment With Respect to Fraud. By checking the box, you are acknowledging you have read, understood and agreed to the acknowledgement.
- b. Consent and Authorization. By checking the box, you are acknowledging you have read, understood and agreed to the terms.

Click here to submit your enrollment: Once you click this button your information will be submitted for enrollment to be effective July 1, 2017. **BE SURE YOU REVIEW ALL INFORMATION FOR ACCURACY PRIOR TO SUBMITTING.**

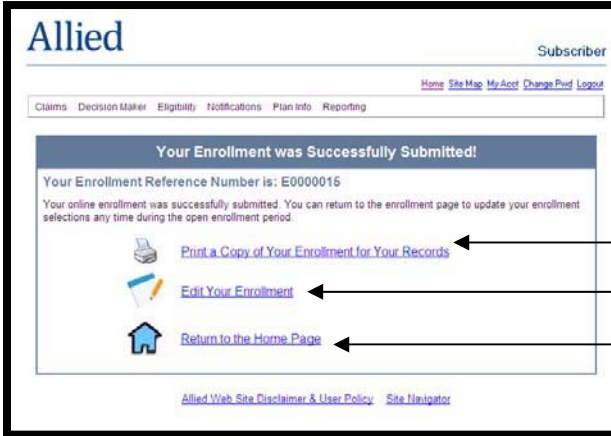
You will see:

Your enrollment was successfully submitted!

You will be issued a Reference Number

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