



**BALL STATE  
UNIVERSITY**

# **BENEFIT ENROLLMENT TUTORIAL**



- Please go to [www.bsu.edu/payroll](http://www.bsu.edu/payroll). Once you are on this page click the grey box on the top left that says “Health and Wellness Benefits”. Select the red box “Log in to Enroll” and you will use your BSU credentials to get logged in.



# Payroll and Employee Benefits

## Health and Wellness Benefits →

Review insurance plans and other benefits for current employees and retirees.

## Payroll →

Find information on wages, deductions, our time clock system, and other matters that affect your pay.

## Retirement Plans →

Discover how to save more for retirement with your Ball State plans.

## Forms, Policies, and Guides →

Download handbooks, insurance forms, helpful guides, and other important documents.

## Time Off →

See our policies, broken down by employee type, for vacation, holidays, sick days, and leaves of absence.

## Tuition Remission →

Want to further your education while working here? We offer tuition remission to our employees.

CONTACT US



- You will be taken to the Communication Portal (shown here). Under *QuickLinks* you will find the open enrollment presentation that will assist you in the benefit enrollment workflow.
- In order to activate the *Enroll Now* button, you will need to complete your *To Do List* and review the required legal notices. To do so click 'Legal Notices' under the *To Do List*.



HOME HEALTH BENEFITS

QuickLinks  
2024 Open Enrollment Presentation

Featured Training  
Legal Notices  
Legal Notices

## Welcome Penny!

Welcome to your insurance enrollment portal. This site gives you easy access to information about Ball State University employee insurance benefits. We recommend that you bookmark this site and check here when you have a benefit related question or need information about your insurance benefits.

If you are **new** to this enrollment portal, you will need to view the **Legal Notices** and acknowledge that you have viewed them on the **To Do List** above before you will be granted access to the Enroll Now box.

To begin your enrollment process, click on the RED area on the right of the screen titled "**Click Here to View Your Benefits.**"

To learn more about your benefit options before you begin the enrollment process, click on the HEALTH BENEFITS drop down above to view information on specific insurance coverages.

To view the insurance presentation, click on the link in the QuickLinks box.

To Do List  
Your To Do List is currently complete

Enroll Now!  
Click Here to View Your Benefits

commonbond  
Have Student Loans?  
Save \$14,000 on average  
CLICK HERE



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- After you acknowledge that you have reviewed the items, select the box next to ‘Please acknowledge that you have reviewed these items.’ Click ‘Submit’ to continue.

HOME

HEALTH BENEFITS ▾

🔍

Legal Notices0% Complete

Legal Notices

Legal Notices

▾ Legal Notices

➔ Legal Notices

Legal Notices

📁

Legal Notices

Please review the below legal notices.

Notice of COBRA Continuation Coverage Rights

Women's Health and Cancer Rights Act Notice

Notice of Privacy Practices


New Health Insurance Marketplace Coverage Options and Your Health Coverage

☒ Please acknowledge that you have reviewed these items.

Click on "Submit" to complete the training program.

Submit

- Click ‘Begin open enrollment’ to begin your enrollment process and make benefit elections.



**Welcome back, Charlie**

Friday, October 11 at 1:43 PM EDT

21

DAYS LEFT TO  
ELECT BENEFITS

[Begin open enrollment](#)

2


TO DO ITEMS


[View to do list](#)


5


ACTIVE BENEFITS


[View benefits](#)

 **Begin open enrollment**

 **Print your benefits**

 **Edit your HSA contribution**

 **Create dependent profile**


 **Update your profile**



# Personal Information Review

Please review your contact information, if any information needs updated please contact our HR Solutions Center at 285-1834

IMPORTANT: The information provided on this screen is the address provided to each of the vendors. You can expect mailings from them including ID cards, FSA/HSA debit cards and explanation of benefits.

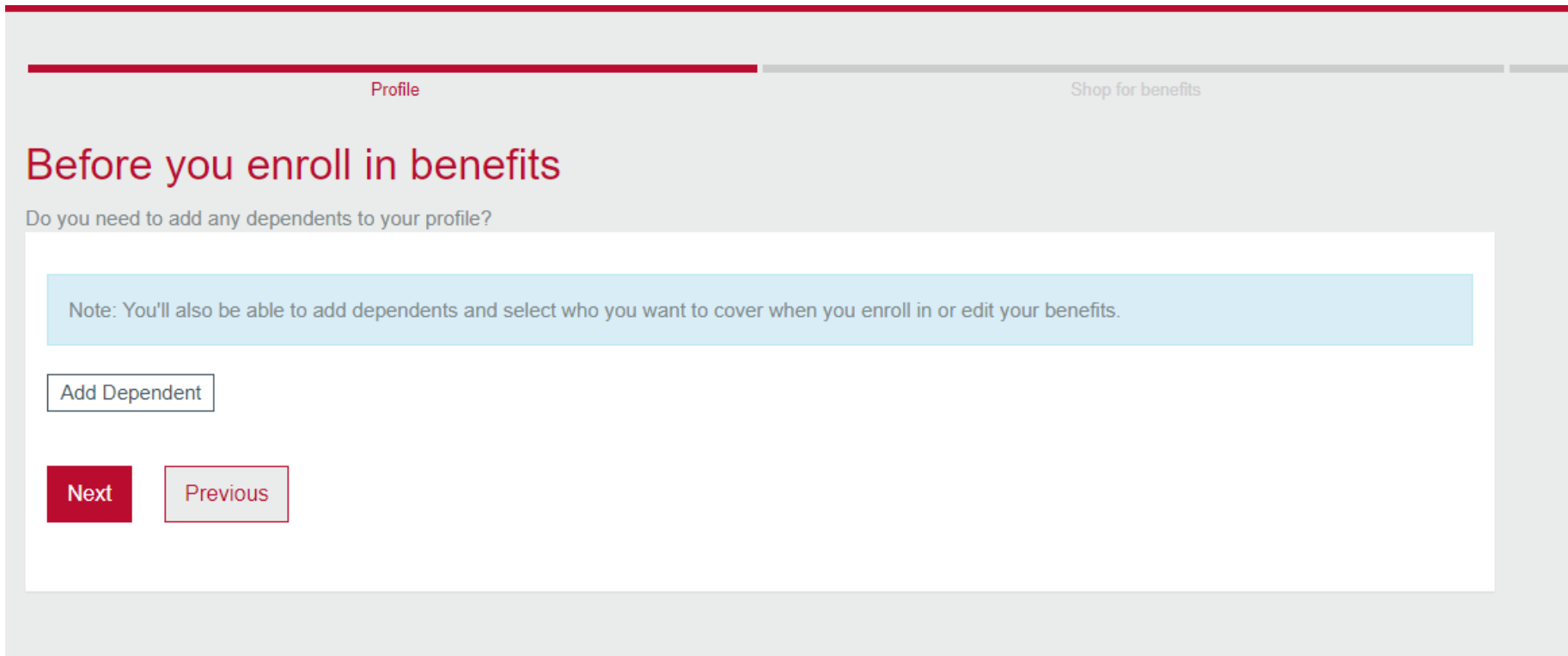
**Your contact information**  [EDIT](#)

Physical address	123 Ball State Way, Muncie, IN 47306, USA
Work email	
Personal email	
Home phone	7652851234
Cell phone	
Work phone	
Work cell phone	
Alternate phone	

[Next step: Review communication preferences](#) [Cancel and return home](#)



- Before you elect any benefits, you can add dependent information on this screen by clicking “Add Dependent” or you may add them later in the process. Click ‘**Next**’ if you want to add them later in the process or you do not have any dependents to add.



Profile Shop for benefits

## Before you enroll in benefits

Do you need to add any dependents to your profile?

Note: You'll also be able to add dependents and select who you want to cover when you enroll in or edit your benefits.

Add Dependent

Next Previous



- To add a dependent, you must complete the specified fields. The \* designates required fields. If the dependent will be added to your medical/dental coverage, a SSN is required.

### Add Dependent

First Name *	Middle Name	Last Name *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Suffix ---Please Select---	Preferred Name <input type="text"/>
-------------------------------	--

Date of Birth \*

Gender \*  
☐ Male ☐ Female

SSN

Relationship \*  
---Please Select---

### Physical Address

☒ Use Employee Address



- Complete the BSU Tobacco Survey by answering the question below. If you answer ‘**No**’ but have completed an approved tobacco-cessation program, contact the Employee Benefits office.
- Click ‘**Save & Continue**’ to proceed to the available benefit offerings.

### Ball State Tobacco Status 2025

**Have you and/or all of your dependents enrolling in a Ball State health plan been tobacco-free for the past six months?**

The employee's answer will pertain to the employee and dependent children on the plan. If a spouse is listed below, you will answer for them separately.

Charlie Cardinal

☐ Yes, I have been tobacco-free for the last six months. I am eligible for the premium discount.

☐ No, I have NOT been tobacco-free for the last six months. I am NOT eligible for the premium discount.

Charlene Cardinal

☐ Yes, I have been tobacco-free for the last six months. I am eligible for the premium discount.




☐ No, I have NOT been tobacco-free for the last six months. I am NOT eligible for the premium discount.

Save & Continue

Cancel

- You will need to complete enrollment for any FSA, HSA and DCAP. All other benefit plans will default to your current coverage. If you wish to review or make a change, select “Begin Enrollment” or “Edit Coverage”

Now it's time to decide on your core benefits.

 <b>Medical</b> Helps cover the cost of medical and surgical expenses.	<div>✓ In your cart</div> <b>PPO Health Plan 2025</b> Covers Charlie C and Charlene C ✎ Requested Coverage Level: Employee and Family Effective 01/01/2025 <a href="#">Show plan details</a> <div>Edit coverage</div>	<b>\$159.08</b> every two weeks
 <b>Health FSA</b> Set aside pre-tax dollars to cover certain out-of-pocket costs for medical, dental and vision.	<div>✓ In your cart</div> <b>Health Care FSA 2025</b> Covers you ✎ Contribution amount: \$3,200.00 Per Plan Year \$123.08 every two weeks Effective 01/01/2025 <a href="#">Show plan details</a> <div>Edit contribution</div> <div>Edit coverage</div>	<b>\$123.08</b> every two weeks
 <b>Dependent Care FSA</b> Pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare.	<div>Decision required</div> <b>Would you like Dependent Care FSA coverage?</b> <div>Begin enrollment</div>	



- If you are adding a spouse you will need to print off the Ball State Working Spouse Affidavit and then upload the completed form to the Document Manager (shown later).

● PROFILE – ● BENEFITS – ○ CHECKOUT

Choose your medical plan.

Please review your options and choose the plan that best meets your needs.

Who do you want to cover on this plan?

✓ Charlie Cardinal

✓ Charlene Cardi...

A note from your HR Administrator

Working Spouse Affidavit

[Ball State U Working Spouse Affidavit](#)

Compare plans & estimate your cost

Personalize your estimate

Your estimated annual cost is based on the details below. Personalize for a more accurate cost estimation.

A note from your HR Administrator

\*\*\*\*If you are a tobacco user, a few tobacco rates may be off by a penny due to rounding issues. The rate reflected on the BSU website is correct.\*\*\*\*

The Working Spouse Affidavit will need to be completed and uploaded to the Document Manager if:

Your spouse was not on the plan for 2024 and you would like to add them to your plan for 2025 or your spouse had an employment or status change in 2024.

[Ball State U Working Spouse Affidavit](#)

Close

Click on Working Spouse Affidavit to print form to complete.



- For dependents you have added in the previous step, select which dependents you want to cover on your medical plan by clicking their name. If you did not previously add your dependents information, you can do so on this screen by clicking **'Add Dependent'**.
- Be sure the person you want to cover for the benefit is green.

## Choose your Medical plan.

Please review your options and choose the plan that best meets your needs.



Who do you want to cover on this plan?

✓ Charlie Cardinal

✓ Cindi Cardinal

✓ Chase Cardinal



- The workflow will show you each health plan option, the premium based on your pay frequency and some plan highlights. From this screen you can compare plans, get additional plan detail by clicking **‘Plan details’** and select your health plan by clicking **‘Select plan’**.
- If you do NOT want any medical coverage, select **‘Decline Coverage’**.

HDHP

HSA

☐ Compare

HSA Qualified Health Plan 2025

\$92.65 Bi-Weekly Cost

Estimated Annual Cost \$9,558.90

How was this calculated?

HSA Tax Savings

Add Contribution

Individual Deductible	\$2,500
Family Deductible	\$5,000
Individual Out of Pocket Max (OOP Max)	\$4,750
Family Out of Pocket Max (OOP Max)	\$7,150 (Individual)/\$8,250 (Family)

Select plan

Plan details

Compare to last year

Plan Documents

PPO

FSA

☐ Compare

PPO Health Plan 2025

\$159.08 Bi-Weekly Cost

Estimated Annual Cost \$10,678.38

How was this calculated?

FSA Tax Savings

Add Contribution

Individual Deductible	\$1,300
Family Deductible	\$3,900
Individual Out of Pocket Max (OOP Max)	\$4,050
Family Out of Pocket Max (OOP Max)	\$9,750

Currently Selected

Plan details

Compare to last year

Plan Documents

Decline Coverage

I would like to decline Medical coverage.

Next

Previous

Cancel



- Acknowledgement of the Ball State Tobacco Usage will pop up.
- Click “I Agree” box and then “Next” to continue, click Edit if you need to make a change.

MEDICAL

Medical

Acknowledgement and Agreement

Acknowledgement and Agreement

Over the past several years the University has promoted the value and importance of a healthy lifestyle through both our benefits and our Working Well programs. We are continuing this initiative by providing an annual tobacco-free premium discount to Employees who have certified that they and any of their dependents, who are enrolled in a Ball State University health plan, are “tobacco-free.” The annual discount for 2025 will remain at \$900 or \$75 per month. A new tobacco-free certification must be completed annually to receive the discount for each calendar year.

As an alternative to completing the certification, the Employee and/or their dependents that are tobacco-users may successfully complete a University approved smoking cessation program to receive the premium discount. For information regarding approved programs, please contact Working Well at 765-285-9355 or [workingwell@bsu.edu](mailto:workingwell@bsu.edu).

By checking the box below, I hereby certify that the answer I provided in the tobacco survey is complete and true.

I understand that tobacco includes any form of tobacco products that are smoked (e.g., cigarettes, cigars, pipes, electronic cigarettes), applied to the gums (e.g., dipping, chewing tobacco, or snuff), and/or inhaled.

I understand that if I, and/or any of my enrolled dependents, begin use of tobacco products I am no longer eligible for the premium discount and must report this change to the Employee Benefits Office.

I understand that I, and/or any of my enrolled dependents, may be subject to testing for nicotine at any time during the Plan Year 2025. Refusal to submit to testing for nicotine will result in the removal of the Tobacco-Free Premium Discount.

I understand that if I and/or my enrolled dependents use tobacco products and do not notify the University, or if I falsify my “tobacco-free” status on this affidavit, I may face penalties including retroactive collection of additional premiums, cancellation of my health coverage, and disciplinary action.

☐ I agree

Next

Previous

Cancel



- Based on the health plan you selected, you will be asked if you want to participate in the corresponding tax advantage account.
- If you selected the PPO Health Plan or declined medical coverage; you will be asked if you want to enroll in a Health FSA. To enroll, enter your desired contribution amount *within the limits* and click '**Next**'.

## Choose your Health FSA plan.

Do you want to participate in a Flexible Spending Account?

Health Care FSA 2025

Select plan

[Decline Coverage](#) I would like to decline Health FSA coverage.

Previous

Cancel

## Health FSA

How much money do you want to contribute to your *Health FSA* account?

You can contribute between \$100.00 and \$3,200.00 per plan year.

Contribution Amount

The amount you enter will be divided into individual deductions over the remainder of the year.

[Decline Coverage](#) I would like to decline Health FSA coverage.

Next

Previous

Cancel



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- If you selected the HSA Qualified Plan, you will be asked if you want to open an HSA. Remember in order to receive the University’s contribution, you must contribute via payroll deduction a minimum of 25% of the University’s contribution.
- Note: Your HSA contribution can be changed as often as needed, at anytime during the calendar year.

### Would you like a Health Savings Account (HSA)?

An HSA allows you to pay for current healthcare expenses and save for those in the future. Its first advantage is that contributions made through payroll deduction are pre-tax. Second, the interest earned is tax-free. Even if you had an HSA in previous years, you must re-enroll every benefit year.

1. Would you like an HSA?

☒ Yes, I would like an HSA.

☐ No, I do not want an HSA.

Continue

Previous

Cancel & return home

- When electing an HSA, the workflow will populate the University's contribution based on your coverage level and pay frequency. It will not allow you to over contribute your annual IRS amount.
- You will need to set up a Repeating or One time contribution. Make sure you elect a starting date as to when you want your contribution taken out of your paycheck. Enter how much per paycheck you want to contribute on your own (minimum of 25% of the University's contribution). Then click '**continue**'
- Once you have made all your contribution elections scroll to the bottom of the screen and click "Save and continue"



## 2. How would you like to contribute to your HSA?

☒ Custom amount  
Contribute a custom amount to be deducted from one or multiple paychecks.

**Continue** Previous Cancel & return home

## 3. Select a way to contribute to your HSA

☐ One time Contribution  
Schedule an amount to be deducted from one specific paycheck.

☒ Custom paycheck range  
Schedule an amount to be deducted from a custom range of paychecks.

Amount: 100.00 from Start date: 01/10/2025 to End date: 12/26/2025 x 26 paychecks = \$2600.00

**Continue** Previous Cancel & return home



- Based on the health plan you selected, you will be asked if you want to participate in the corresponding tax advantage account.
- If you selected the HSA Qualified Health Plan; you will be asked if you want to enroll in a Limited-Purpose Healthcare FSA. To enroll, enter your desired contribution amount *within the limits* and click ‘**Next**’.

### Choose your Health FSA plan.

Do you want to participate in a Flexible Spending Account? Since you are contributing to a Health Savings Account, the Flexible Spending Account is considered a "Limited-Purpose FSA". A Limited-Purpose FSA allows you to contribute funds for eligible expenses that are limited to "other expenses" like dental and vision expenses. The IRS does not allow anyone to contribute to both a Health Savings Account and a general-purpose Health FSA since both apply funds toward medical expenses.

Your enrollment has changed, which requires you to select a new Health FSA plan.

Limited-Purpose Healthcare FSA 2025

Select plan


[Decline Coverage](#)

I would like to decline Health FSA coverage.

Previous

Cancel

- Regardless of the medical plan you chose; you are eligible to enroll in a Dependent Care FSA. In order to complete your 2025 Open Enrollment you are required to make a decision on this plan coverage. Start by selecting “Begin Enrollment” you can select Decline Coverage at the bottom *or* enter your desired contribution amount *within the IRS limits* and click ‘**Next**’. Again, this FSA is *only* for qualified daycare expenses.

**Dependent Care FSA**

Pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare.

Decision required

Would you like Dependent Care FSA coverage?

Begin enrollment

### Choose your Dependent Care FSA plan.

Do you want to participate in a Dependent Care Flexible Spending Account?

Dependent Care FSA 2025

Select plan

Decline Coverage

I would like to decline Dependent Care FSA coverage.

Previous

Cancel

- If you have selected to cover any dependents, you may be routed to the Document Manager. This is where you will need to upload any/all supporting documentation.
- Example: Ball State Working Spouse Affidavit and marriage certificate if adding a spouse. Birth certificate for child(ren).
- Click the **'Add Document'** button.

## Document Center

View, manage, and upload your documents



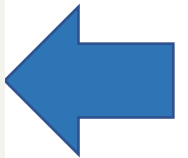
Hi Charlie! You have one request for documents.

Document needed

Add document to verify Charlene (spouse) is your dependent.

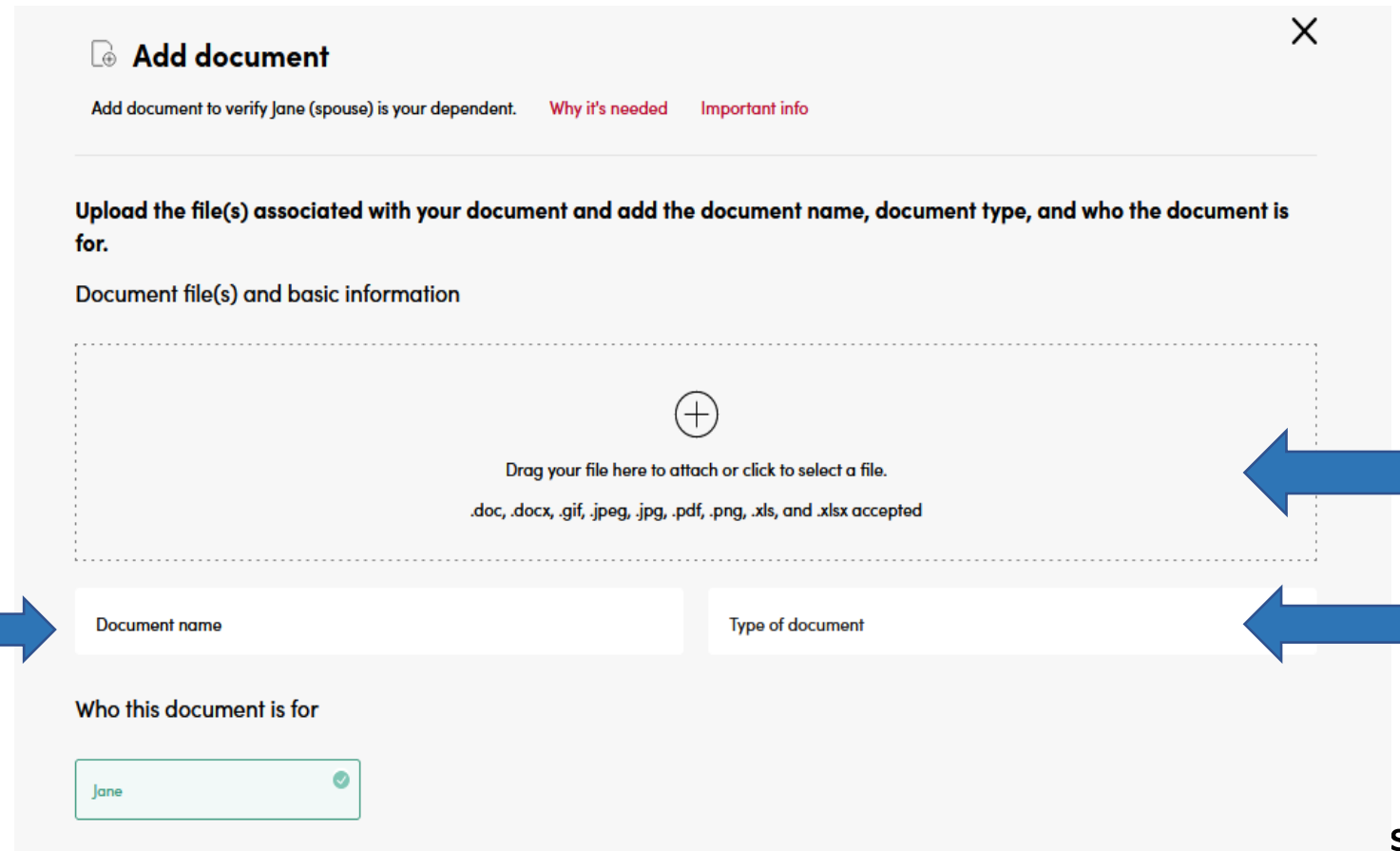
[Why it's needed](#) [Important info](#)

Add document



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- To add documentation, you will need to click the + sign or drag the document to the box. Complete the document name
- Select the drop down under type of document. If none of the categories match the uploaded documentation, choose **'Other'**.




**Add document** ✕

Add document to verify Jane (spouse) is your dependent. [Why it's needed](#) [Important info](#)

Upload the file(s) associated with your document and add the document name, document type, and who the document is for.

Document file(s) and basic information




Drag your file here to attach or click to select a file.  
.doc, .docx, .gif, .jpeg, .jpg, .pdf, .png, .xls, and .xlsx accepted

Document name

Type of document

Who this document is for

Jane 

- For Open Enrollment the workflow will stop, if you are processing as a new hire the workflow will then direct you to the dental coverage option. First, it will ask you who you want covered on the dental plan. Select which dependents you want to cover on your dental plan by clicking on their name and clicking '**Next**'. If you did not previously add your dependents information, you can do so by clicking '**Add Dependent**'.
- If you do NOT want dental coverage, select '**Decline Coverage**'.

**Dental**

Provides coverage to save you money and help ensure a healthy smile.

**X Declined**

You have declined this benefit.  
Change your mind? Hit "edit coverage" below.

Edit coverage

Please choose your coverage level and select your plan.

**Who do you want to cover on this plan?**

✓ Charlie Cardinal

Charlene Cardinal



- The workflow will show you the dental plan option, the premium based on your pay frequency and some plan highlights. From this screen you can get more benefit detail by clicking ‘**Plan details**’, view the plan documents and select your dental plan option. Click ‘**Select plan**’ to elect coverage.

If you do NOT want dental coverage, select ‘**Decline Coverage**’.

Dental Plan 2025

Diagnostic & Preventive	100% with Delta Dental PPO Dentist 100% with Delta Dental Premier Dentist
Basic Services	85% with Delta Dental PPO Dentist 80% with Delta Dental Premier Dentist
Major Services	70% with Delta Dental PPO Dentist 70% with Delta Dental Premier Dentist
Orthodontic Services to age 19 - braces	70% with Delta Dental PPO Dentist 70% with Delta Dental Premier Dentist

✓ Currently Selected

Plan details

Compare to last year

Plan Documents ▾

Decline Coverage

I would like to decline Dental coverage.

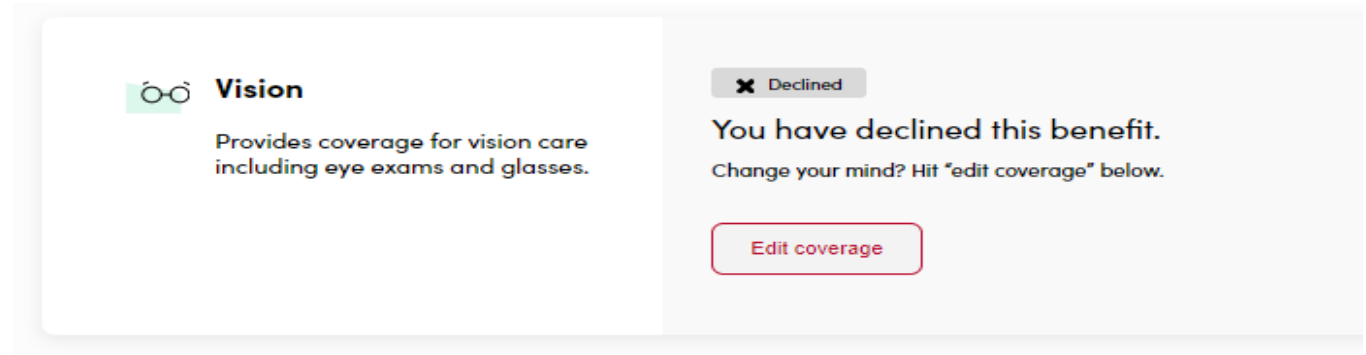
Next

Previous

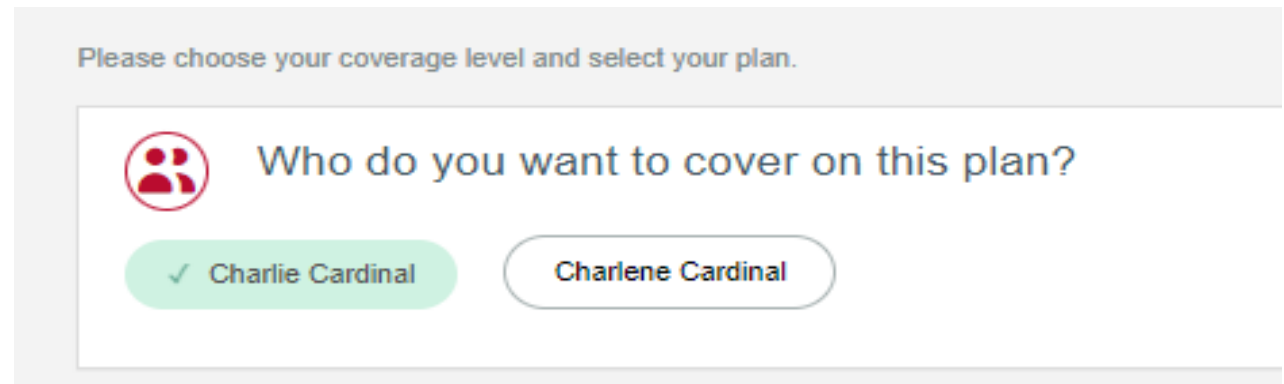
Cancel

The workflow will then direct you to the vision coverage option. First, it will ask you who you want covered on the vision plan. Select which dependents you want to cover on your vision plan by clicking on their name and clicking **'Next'**. If you did not previously add your dependents information, you can do so by clicking **'Add Dependent'**.

If you do NOT want vision coverage, select **'Decline Coverage.'**



This screenshot shows the 'Vision' coverage selection screen. On the left, there is a section titled 'Vision' with a glasses icon. Below the title, it states: 'Provides coverage for vision care including eye exams and glasses.' On the right, there is a 'Declined' status indicator (a grey box with an 'X' icon and the word 'Declined'). Below this, a message reads: 'You have declined this benefit. Change your mind? Hit "edit coverage" below.' At the bottom right, there is a red-outlined button labeled 'Edit coverage'.




This screenshot shows the dependent selection screen. At the top, a grey header bar contains the text: 'Please choose your coverage level and select your plan.' Below this, the main heading is 'Who do you want to cover on this plan?' accompanied by a red icon of two people. There are two selectable options below: 'Charlie Cardinal' is selected, indicated by a green checkmark and a green background; 'Charlene Cardinal' is not selected, indicated by a grey background.

- The workflow will show you the vision plan options, the premium based on your pay frequency and some plan highlights. From this screen you can get more detail on each plan by clicking ‘**Plan details**’, view the plan documents and select your vision plan option. Click ‘**Select plan**’ to elect coverage.

If you do NOT want vision coverage, select ‘**Decline Coverage**’.


### Basic Coverage 2025

WellVision Exam	\$15 copay
Prescription Glasses	\$25 copay
Contacts (instead of glasses)	Up to \$80 copay for your contact lens exam, \$150 allowance for contacts
Glasses and Sunglasses	Average 20-25% savings on noncovered lens options

[Select plan](#) [Plan details](#) [Compare to last year](#) [Plan Documents](#) 

### Premier Coverage 2025

WellVision Exam	\$0 copay
Prescription Glasses	\$0 copay
Contacts (instead of glasses)	Up to \$80 copay for your contact lens exam, \$200 allowance for contacts
Glasses and Sunglasses	Average 20-25% savings on noncovered lens options

[Select plan](#) [Plan details](#) [Compare to last year](#) [Plan Documents](#) 

[Decline Coverage](#) I would like to decline Vision coverage.

[Previous](#) [Cancel](#)

- You will be required to designate a beneficiary for the basic life coverage. Choose the beneficiary type that indicates your selection.

If you select '**Person**' and you have any dependents listed previously, you may simply click the button next to their information.

Or you can select '**Enter New beneficiary**'.

**Life: Beneficiary information**

Beneficiary type?

**Please Note:**  
A beneficiary is a person, organization, trust, or estate designated by the certificate holder to receive proceeds from a policy when the certificate holder becomes deceased. You will be able to name multiple persons, organizations and/or trusts as primary and/or secondary beneficiaries and designate allocation percentages for each.

☒ Person ☐ Estate  
☐ Organization ☐ Other  
☐ Trust

**Next** **Previous** **Cancel**

**Life: Beneficiary information**


Please choose an existing dependent if applicable, otherwise click next to enter a new beneficiary.

☐ Enter New beneficiary

Dependents Eligible To Be Used As Beneficiaries


Use	Name	Relationship
<input checked="" type="radio"/>	John Doe	Spouse

**Next** **Previous** **Cancel**



- The workflow will then direct you to the basic life coverage. This is a mandatory benefit that is subsidized by the University at 75%. You cannot decline this benefit. This is just for informational purposes showing you your coverage amount and your portion of the premium based on your pay frequency.

Click **‘Save’** to continue.



**Life**

**Basic Life 2025**


Offered By: The Hartford


Coverage Amount: \$103,000.00 (2.06 times salary up to \$125,000.00)

Imputed Income: \$3.67 per pay period [What's this?](#)


Effective Date: 10/01/2024

You Pay: \$3.14 every two weeks

**Beneficiaries**  [Edit](#)

[Show details](#) 

**Additional Information**

[Show details](#) 

**View coverage**

- To add a beneficiary, you need to complete the specified fields. The \* designates required fields.

Then click **‘Next’**.

### Life: Beneficiary information

Enter the beneficiary information.

First Name *	Middle Name	Last Name *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship *	Social Security Number	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address 1	Address 2	City
<input type="text"/>	<input type="text"/>	<input type="text"/>
ZIP / Postal code	Country	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Next

Previous

Cancel

- Once you have added/selected your beneficiary, you need to complete the **‘Beneficiary Type’** and **‘Allocation %’**. You may have multiple beneficiaries but the allocation % has to add up to 100%. You may also designate a secondary beneficiary in addition to your primary.

Profile

Shop for benefits

Confirm & Finish

### Life: Beneficiary information

Please select the beneficiaries for this benefit, specifying whether they are Primary or Secondary as well as the allocation percentage(s).

Note: When replacing an existing beneficiary with a new one, first deselect the beneficiary, add the new beneficiary, then adjust the allocation percentage accordingly.

Use	Name	Relationship	Date of Birth	SSN/ID	Beneficiary Type	Allocation %	Actions
<input checked="" type="checkbox"/>	Jane Doe	Spouse	05/01/1980	123-45-6789	Primary	100	<button>Edit</button>

Add Beneficiary

Please Note:  
Secondary beneficiaries will receive proceeds in the event that all primary beneficiaries are no longer living.

NextPreviousCancel





- The workflow will then direct you to the voluntary life coverage. If you would like to elect the additional life coverage, click the button next to your desired '**Coverage amount**', and '**Next**'. Premiums are shown based on your pay frequency, age, amount. During OE, if you have this coverage you may increase 1 increment without EOI required.

If you do NOT want voluntary life coverage, select '**Decline Coverage**'.

Note: You must elect coverage for yourself in order to elect spousal or dependent coverage.

### Voluntary Life 2025

Coverage amount	Bi-Weekly Cost
<input type="radio"/> \$10,000.00	\$0.46
<input type="radio"/> \$20,000.00	\$0.92
<input type="radio"/> \$30,000.00	\$1.38
<input type="radio"/> \$40,000.00	\$1.85
<input checked="" type="radio"/> \$50,000.00	\$2.31
<input type="radio"/> \$60,000.00	\$2.77
<input type="radio"/> \$70,000.00	\$3.23
<input type="radio"/> \$80,000.00	\$3.69
<input type="radio"/> \$90,000.00	\$4.15

☒ Currently Selected

[Decline Coverage](#) I would like to decline Voluntary Life coverage.

Please Note:  
The guaranteed issue amount for this benefit is \$200,000.00.

- If you elected above the guarantee issue amount, you must complete *Evidence of Insurability with The Hartford*. Click the link “My Evidence of Insurability” to be directed to The Hartford’s online health form. You may also save this task for later by selecting “complete later” and it will remain in your To Do Items until completed.

## Hartford Evidence of Insurability

Please Complete Your Evidence of Insurability.

Please click on 'My Evidence of Insurability' to sign on to your Evidence of Insurability (EOI) provider's website.

My Evidence of Insurability

Complete later

Return home

7  
DAYS LEFT TO  
ELECT BENEFITS

[View your benefits](#)

1  
TO DO ITEMS

[View to do list](#)

10  
ACTIVE  
BENEFITS

[View benefits](#)

Print your  
benefits



Complete  
evidence of  
insurability



Edit your HSA  
contribution



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- If you elected voluntary life coverage complete your beneficiary designation.

Profile

Shop for benefits

Confirm & Finish

### Voluntary Life: Beneficiary information

Please select the beneficiaries for this benefit, specifying whether they are Primary or Secondary as well as the allocation percentage(s).

Note: When replacing an existing beneficiary with a new one, first deselect the beneficiary, add the new beneficiary, then adjust the allocation percentage accordingly.

Use	Name	Relationship	Date of Birth	SSN/ID	Beneficiary Type	Allocation %	Actions
<input checked="" type="checkbox"/>	Jane Doe	Spouse	05/01/1980	123-45-6789	Primary	100	Edit
<input checked="" type="checkbox"/>	Joy Doe	Daughter			Secondary	100	Edit

Add Beneficiary

Please Note:  
Secondary beneficiaries will receive proceeds in the event that all primary beneficiaries are no longer living.

Next

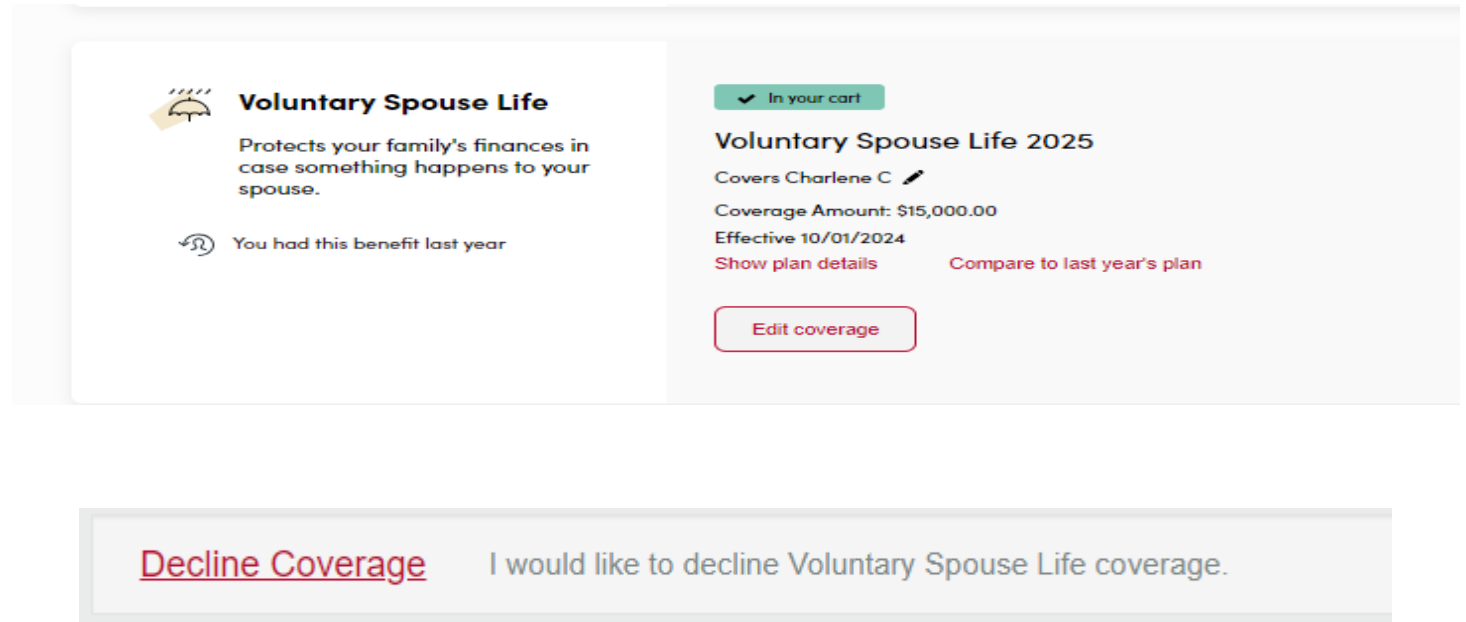
Previous

Cancel



- If you elected voluntary life coverage on yourself, you will be asked if you want to elect voluntary spouse life coverage. For a spouse you have added in a previous step, select them by clicking the box next to their information and clicking **'Next'**. If you did not previously add your spouse's information, you can do so by clicking **'Add Dependent'**.

If you do NOT want voluntary spouse life coverage, select **'Decline Coverage'**.



The screenshot displays a user interface for selecting "Voluntary Spouse Life" coverage. On the left, a card titled "Voluntary Spouse Life" features an umbrella icon and a description: "Protects your family's finances in case something happens to your spouse." Below this, a circular arrow icon indicates "You had this benefit last year". On the right, a summary section shows a green "In your cart" status, the plan name "Voluntary Spouse Life 2025", and details for "Charlene C." including a coverage amount of \$15,000.00 and an effective date of 10/01/2024. Links for "Show plan details" and "Compare to last year's plan" are provided. An "Edit coverage" button is located at the bottom of the summary. At the bottom of the entire interface, a "Decline Coverage" link is shown next to a text box containing the statement: "I would like to decline Voluntary Spouse Life coverage."

- If you want to elect the voluntary spouse life coverage, click the button next to your desired '**Coverage amount**', followed by '**Select plan**' and '**Next**'. Premiums are shown based on your pay frequency.

If you do NOT want voluntary spouse life coverage, select '**Decline Coverage**'

Voluntary Spouse Life 2025

Coverage amount	Bi-Weekly Cost
<input type="radio"/> \$5,000.00	\$0.30
<input type="radio"/> \$10,000.00	\$0.60
<input checked="" type="radio"/> \$15,000.00	\$0.90
<input type="radio"/> \$20,000.00	\$1.20
<input type="radio"/> \$25,000.00	\$1.50
<input type="radio"/> \$30,000.00	\$1.80
<input type="radio"/> \$35,000.00	\$2.10
<input type="radio"/> \$40,000.00	\$2.40

✓ Currently Selected

[Decline Coverage](#) I would like to decline Voluntary Spouse Life coverage.



- If you elected voluntary life coverage on yourself, you will be asked if you want to elect voluntary child life coverage. For a child(ren) you have added in a previous step, select them by checking the box next to their information and clicking **‘Next’**. If you did not previously add your child(ren)’s information, you can do so by clicking **‘Add Dependent’**.

If you want to elect the voluntary child life coverage, click the button next to your desired **‘Coverage amount’**, followed by **‘Select plan’** and **‘Next’**. Premiums are shown based on your pay frequency.

If you do NOT want any voluntary child life coverage, select **‘Decline Coverage’**.

### Choose your Voluntary Child Life plan.

Please review your options and choose the coverage amount that best meets your needs.

Who do you want to cover on this plan?

✓ Chaz Cardinal

Voluntary Child Life 2025

Coverage amount	Bi-Weekly Cost
<input type="radio"/> \$5,000.00	\$0.23
<input type="radio"/> \$10,000.00	\$0.46

Select plan

Decline Coverage

I would like to decline Voluntary Child Life coverage.

Next

Previous

Cancel

- The workflow will then direct you to the Long-Term Disability coverage. This is a mandatory benefit that is subsidized by the University at 75%. You cannot decline this benefit. This is just for informational purposes showing you your coverage amount and your portion of the premium based on your pay frequency.

Click '**Next**' to continue.

## Long-Term Disability 2024 plan.

Please review your coverage amount below.

Monthly benefit equals 60% of 103% of your base salary, up to a maximum monthly benefit of \$15,000.

### Long Term Disability 2024

Coverage amount: \$3,800.00 per month (60% of monthly salary)

✓ Currently Selected

**Please Note:**  
This benefit cannot be declined.

[Next](#) [Previous](#) [Cancel](#)



- The workflow will show you the Voluntary Short Term Disability plan options. If you want to elect the voluntary short term disability coverage, click the button next to your desired '**Coverage amount**', followed by '**Select plan**' and '**Next**'. Premiums are shown based on your pay frequency.

If you do NOT want voluntary short term disability coverage, select '**Decline Coverage**'.

*Service Employees are not eligible for this benefit.*

**Choose your Voluntary Short Term Disability plan.**  
Please review your options and choose the coverage amount that best meets your needs.

**Voluntary Short Term Disability (13 week duration; 8th day commencement)**

Coverage amount	Ten Times Per Year Cost
<input type="radio"/> \$100.00 per week	\$6.82
<input type="radio"/> \$200.00 per week	\$13.25
<input type="radio"/> \$300.00 per week	\$19.07
<input type="radio"/> \$400.00 per week	\$26.50
<input type="radio"/> \$500.00 per week	\$33.12

Select plan

**Voluntary Short Term Disability (13 week Duration; 30th day commencement)**

Coverage amount	Ten Times Per Year Cost
<input type="radio"/> \$100.00 per week	\$3.52
<input type="radio"/> \$200.00 per week	\$7.03
<input type="radio"/> \$300.00 per week	\$10.55
<input type="radio"/> \$400.00 per week	\$14.06
<input type="radio"/> \$500.00 per week	\$17.58

Select plan

**Voluntary Short Term Disability (26 week duration; 8th day commencement)**

Coverage amount	Ten Times Per Year Cost
<input type="radio"/> \$100.00 per week	\$3.95
<input type="radio"/> \$200.00 per week	\$7.90
<input type="radio"/> \$300.00 per week	\$11.86
<input type="radio"/> \$400.00 per week	\$15.81
<input type="radio"/> \$500.00 per week	\$19.76

Select plan

**Voluntary Short Term Disability (26 week duration; 30th day commencement)**

Coverage amount	Ten Times Per Year Cost
<input type="radio"/> \$100.00 per week	\$4.91
<input type="radio"/> \$200.00 per week	\$9.82
<input type="radio"/> \$300.00 per week	\$14.72
<input type="radio"/> \$400.00 per week	\$19.63
<input type="radio"/> \$500.00 per week	\$24.54

Select plan

**Decline Coverage** | I would like to decline Voluntary Short Term Disability coverage.

Next Previous Cancel



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- You are almost done. Review your full benefit summary and make changes if needed. To complete your enrollment, click the box that you have reviewed the information and click **'Complete Enrollment'**.

		\$171.20 per times per year
<b>Your Medical coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	HSA Qualified Health Plan	
Offered By:	Aetna-HMO	
Requested Coverage Level:	Employee and Family	
Effective Date:	09/19/2016	
Persons Covered:	John Doe, Jane Doe	
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your Health Savings Account (HSA) coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Health Savings Account	\$400.00 per benefit year
<b>Your Contributions:</b>		
Employee Per Pay Period Contribution:	\$100.00 Ten Times A Year (09/20/2016 - 12/30/2016)	
Total Employee Ongoing Contribution:	\$400.00 per benefit year	
Total Employer Contribution:	\$400.00 per benefit year	
<b>Employer Contributions:</b>		
Employee Ongoing Contributions:	\$0.00 \$0.00 per benefit year	
Total Employer Contributions:	\$0.00 \$0.00 per benefit year	
Total Employer and Employee Contributions:	\$0.00 \$0.00 per benefit year	
Offered By:	HSA Bank	
Effective Date:	09/21/2016	
Persons Covered:	John Doe	
<a href="#">Edit contribution</a>	<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>
<b>Your Dependent Care FSA coverage</b> <b>You have selected the plan below!</b>	FY-Your dependent care fund	
<a href="#">Edit coverage</a>		
<b>Your Dental coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	DentalPlan	\$0.00 Jan but income per year
Offered By:	Dentix Company of Indiana	
Requested Coverage Level:	Employee and Family	
Effective Date:	Jan 19/2016	
Persons Covered:	John Doe, Jane Doe	
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your Vision coverage</b> <b>You have selected the plan below!</b>	Vision	
<a href="#">Edit coverage</a>		
<b>Your Life coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Main Life	\$01,100 but income per year
Offered By:	The Hartford	
Coverage Amount:	\$1,000,000 (\$1,000,000 term; voluntary up to \$1,000,000.00)	
Completed Enrollment:	Yes No Yes No Yes No <b>Voluntary Select?</b>	
Effective Date:	09/19/2016	
Persons Covered:	John Doe	
Beneficiaries:	Jane Doe, Jay Doe	<a href="#">Add</a>
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your AD&amp;D coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Main AD&D	\$01,400 but income per year
Offered By:	The Hartford	
Coverage Amount:	\$1,000,000 (\$1,000,000 term; voluntary up to \$1,000,000.00)	
Effective Date:	09/19/2016	
Persons Covered:	John Doe	

		\$30.19 per times per year
<b>Your Voluntary Life coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Voluntary Life	
Offered By:	The Hartford	
Requested Coverage Amount:	\$210,000.00	
Effective Date:	09/19/2016	
Persons Covered:	John Doe	
Beneficiaries:	Jane Doe, Jay Doe	<a href="#">Add</a>
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your Voluntary Spouse Life coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Voluntary Spouse Life	\$3.00 per times per year
Offered By:	The Hartford	
Coverage Amount:	\$25,000.00	
Effective Date:	09/19/2016	
Persons Covered:	Jane Doe	
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your Voluntary Child Life coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Voluntary Child Life	\$1.20 per times per year
Offered By:	The Hartford	
Coverage Amount:	\$10,000.00	
Effective Date:	09/19/2016	
Persons Covered:	Jay Doe	
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your Long-Term Disability coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Long Term Disability	\$3.52 per times per year
Offered By:	The Hartford	
Coverage Amount:	\$2,000.00 per month (61% of monthly salary maximum of \$1,000.00 per month)	
Effective Date:	09/19/2016	
Persons Covered:	John Doe	
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	
<b>Your Short-Term Disability coverage</b> <b>You have selected the plan below! You have 41 days to make changes to your coverage.</b>	Short Term Disability	\$19.87 per times per year
Offered By:	The Hartford	
Coverage Amount:	\$500.00 per week	
Effective Date:	09/19/2016	
Persons Covered:	John Doe	
<a href="#">Edit coverage</a>	<a href="#">Show Plan Details &gt;</a>	



☐ I have reviewed the information above





## Complete Enrollment

Cancel




- You will then get a screen confirming your benefit selections. After reviewing this screen click the green “Continue to next page” button.
- You will then be asked to complete a survey and then go to the final screen.
- You have now completed your benefit enrollment.

✓ Congratulations Charlie, you have finished selecting your benefits!

 <b>Medical</b> HSA Qualified Health Plan 2024 Just You	 <b>Health Savings Account (HSA)</b> Health Savings Account 2024	 <b>Health FSA</b> Limited-Purpose Healthcare FSA 2024	 <b>Dental</b> Dental Plan 2024 Just You
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[Show all 9 of my benefits](#) ▼

**Helpful things to do right now**



Review and print a copy of your [Benefit Detail Report](#)

Congratulations, you have completed your Benefits Open Enrollment for the 2024 calendar year! If you want further verification of your open enrollment elections or tobacco status, please call 1-765-285-1834. Please print your enrollment details fo [Show more](#) ▼

[Continue to next page](#)

[View and edit all benefits](#)



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