

Friday, April 04, 2008

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## Login

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View Employer

- Summary**
- Group List
- Member List
- Employer Documents

The Summary tab will give you the specifics of your particular plan.

**Employer Number:** 10

**Name/Address**

Name: COLLEGE TEST GROUP  
 Address:  
 City/St/Zip: 00000  
 Contact: Don Johnson  
 E-Mail:  
 Phone No: (777) 777-7777

Date Group Started: 5/1/2001  
 Deductible Begin Month: December  
 Federal ID#: 11-2446666  
 Group Policy Number: XXX01234  
 Months to receive claims: 12  
 Pre-existing months to check: 12  
 Member Wait Days/Months: 90  
 Member Begins 1st of Month:

**Auto Flex Options**

Medical	Dental	Vision	Drug
Misc	M&N		

**Coverages**

Medical	Dental	Vision	Drug
Misc	Life	LTD	STD

	PPO	Plan #	Begin Date
In Network:	Beech Street Corp/ Healthcare Preferred	22	1/1/2000
Out of Network:		22	4/1/2006





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#### Showing: Employer Documents

Name	Description	Size
CORRESPONDENCE		
<a href="#">testcollegestudentletter.doc</a>	termination letter from College Student	21 KB
Enrollment Form		
<a href="#">TESTCOLLEGEENROLLMENTFORM.pdf</a>	TEST COLLEGE ENROLLMENT FORM	58 KB
ILLNESS CLAIM FORM		
<a href="#">Accidental Sickness Claim Form College Test.pdf</a>	Accident and Sickness Claim form College Test	15 KB
Schedule Of Benefits		
<a href="#">SummaryofCoverageTestCollege.pdf</a>	TEST COLLEGE MY BENEFITS AT A GLANCE	65 KB

The Employer Documents tab will provide you access to view and download the forms specific to your program.





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### Generate Reports

- Benefit Utilization**
- Specific Report
- Claims Summary
- Custom Reports
- My Reports

#### Showing: Groups

Select a group to be included in the Report and click the Request Report button.

Emp	Group	Name	Address	City	State	Effective Date
10		COLLEGE TEST GROUP				5/1/2001

The Reports tab allows an Employer or Administrator the access to run either specific or even custom reports in order to review their particular program.

I want this report for the period:

to be generated:

Request Report





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**Enrollment Form - Applicant Information**

\*=required fields

When you are done entering your information, please click the Next button to continue your enrollment.

This is an example of an Enrollment Form that is available online.

**Primary Applicant (Candidato Principal)**

Reason For Enrollment (Razon para la inscripcion):

I am enrolling (Estoy inscribiendo):

Last Name (Apellido): \*

First Name (Primer nombre): \*

Middle Initial (Inicial):

Marital Status (Estado civil): \*  
 single     married     other

SSN (Numero de seguro Social): \*

Birth Date (Fecha de nacimiento): \*  
 mm/dd/yyyy

Sex (Sexo): \*     male/hombre     female/mujer

Email (Correo electronico):

Other Health Insurance? (Tiene otro seguro medico?): \*     yes (si)     no (no)

**Spouse (Esposo/a)**

Last Name (Apellido): \*

First Name (Primer nombre): \*

Middle Initial (Inicial):

Marital Status (Estado civil): \*  
 single (soltero/a)     married (casado/a)     other (otro)

SSN (Numero de seguro social):

Birth Date (Fecha de nacimiento): \*  
 mm/dd/yyyy

Sex (sexo): \*     male (hombre)     female (mujer)

Email (correo electronico):

Other Health Insurance? (Tiene otro seguro medico?): \*     yes (si)     no

I Decline Coverage for this Individual? (Yo rechazo cobertura para este individuo?): \*     yes (si)     no

Reason for Declining (Razon por rechazo):

